



*"People
helping people
help
themselves"*

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LTC Financial Audit Frequently Asked Questions (FAQ)

1. What providers will be subject to Long Term Care (LTC) Financial Audits?

Note: This is an update to the November 9, 2012 HMS LTC Audit Webinar.

The Indiana RAC LTC audits will cover all provider type 03-Extended Care Facilities which includes specialty codes 030-Nursing Facilities, 031-Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID formerly ICF/MR), 032-Pediatric Nursing Facility, 033-Residential Care Facility and 034-Psychiatric Residential Treatment Facility. This was not explicitly communicated during the presentation.

2. When will audits occur?

HMS plans to complete the first round of reviews for all provider type 03-Extended Care Facilities over a two year period beginning March 2013.

3. How are providers selected for audit within the first two-year round?

The schedule is typically developed by location.

4. Who will receive an audit notification letter?

The State and HMS jointly issue a notification letter to providers. Correspondence is addressed to the Administrator.

5. What is the review period for the LTC audits?

The audits will cover a three-year review period adjusted by a one-year look-back period from the date when each audit commences. For example, if the review is scheduled in January 2013, the dates of service included in the review will be January 1, 2009 through December 31, 2011. HMS will not include January 1, 2012, through December 31, 2012.

6. What type of documentation will be requested?

LTC audits will be financial audits with record review of an extended care facilities' Census Reports, Detailed Aging Report, and Detailed Financial History Report for the audit period.

7. What supporting documentation may be required?

Financial documentation is required to complete the audit. This generally can be generated from a provider's billing/accounting software program and includes census and accounts receivable reports.

8. What percentage of recipient records will be reviewed?

HMS will review all eligible recipients who received Medicaid benefits within the period under review.

9. How many claims will be reviewed per facility?

HMS will review all Medicaid claims paid to the facility for the dates of service included in the review period.

10. What happens if a possible recipient is not yet approved for Medicaid?

HMS will not be reviewing residents with pending Medicaid eligibility.

11. What is LTC audit protocol to be followed?

HMS will follow the communication, notification and timelines for an audit defined by the Indiana Administrative Code and the administrative appeal process governed by Indiana Code. In addition, HMS, as the Medicaid Recovery Audit Contractor, must comply with the rules established by the Patient Protection and Affordable Care Act of 2009.

12. What happens in the audit process once a potential improper payment is identified by HMS?

HMS sends the provider a preliminary set of report(s) (Patient Income Liability and Potential Claims Error and/or Underpayment) for review and response. Once HMS receives the provider's response, HMS works one-on-one with the provider to resolve any disputed cases. At this point a Draft Audit Findings Letter with a listing of claims is sent to the provider.

13. What are the options for a provider in responding to a Draft Audit Findings Letter?

A provider has three options upon receiving a Draft Audit Findings Letter.

1. If the provider agrees with the Draft Audit Findings, the provider would sign the Audit Reconsideration and Appeal Waiver and therefore waive their right to a future appeal.
2. If the provider disagrees with any of the Draft Audit Findings, the provider would submit a Request for Administrative Reconsideration and submit documentation to support their disagreement.
3. If the provider does not submit a Request for Administrative Reconsideration within the required 45 calendar-day timeframe, the provider forfeits their appeal rights.

At the conclusion of each of these response (or non-response) options, a Final Calculation of Overpayment is issued to the provider with the overpayment identified, interest calculated, and a

timeframe for appeal (if the provider still has appeal rights) established, along with explanation of their repayment option.

Upon receipt of the Final Calculation of Overpayment, a provider can:

1. Agree and proceed to repayment;
2. File a timely appeal (would not apply if appeal rights are waived or forfeited through the Draft Audit Findings process);
3. Forfeit appeal rights by not filing a timely appeal within the required 60 day timeframe.

14. In terms of "underpayment", will the State net the underpayment findings with the overpayment findings?

No, providers will not be allowed to net the overpayment findings by the underpayments identified. If the underpayment falls within the one year look-back period, the provider can submit a claims adjustment. For all other underpayments, HMS will educate the provider on modifying billing practices to prevent or identify underpayment in a timely manner to permit adjustments.

15. If there are overpayment findings, will interest be assessed? If so, what is the date when interest starts to accrue?

Yes. Interest will be assessed on identified overpayments. The beginning date for interest calculation is the later of the claim paid date or the date the overpayment actually resulted in additional funds to a provider.

16. Do the LTC audits overlap with any other State-directed audit?

The Office of Medicaid Policy and Planning (OMPP) provides oversight of the Medicaid RAC and approves all providers who will be audited by HMS. Prior to approval, OMPP will work to avoid overlaps with planned Minimum Data Set (MDS) audits. Additionally, OMPP coordinates all audits within their purview with other CMS Medicaid Audits such as MIC audits.