INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Provider and Member Utilization Review

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Revision History

Version	Date	Reason for Revisions	Completed By
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1.1	Policies and procedures as of Aug. 1, 2016 Published: Feb. 13, 2017	Scheduled update	FSSA and HPE
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6.0	Policies and procedures as of Sept 1, 2022 Published: Oct. 13, 2022	Scheduled update: • Reorganized and edited text as needed for clarity • Updated web links • Updated the *Program Integrity* section • Added the FADS mailing address to the *Fraud and Abuse Detection System* section • Updated the information required in the *Medical and Financial Record Retention* section • Added the *Recommended Best Practices* section • Updated the *Reporting, Returning and Explaining Overpayments* section and subsections • Updated the *Prepayment Review Claim Status – Remittance Advice* section • Added the *Targeted Probe and Educate* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated information about PERM audit in the *Payment Error Rate Measurement Audits* section • Added additional reasons for referral in the *Member Utilization Review* section	

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Provider and Member Utilization Review

Introduction

> *Note: Review and monitoring guidelines for services provided under the managed care delivery system, other than carved-out services, may be handled by the managed care entity (MCE) in which the provider is enrolled. Each MCE may establish and communicate its own criteria. Questions regarding MCE-specific review and monitoring guidelines for providers enrolled in the managed care delivery system should be directed to the MCE in which the provider is enrolled. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*
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> *For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.*

Utilization review guards against unnecessary medical care and services, and it ensures that payments are appropriate according to the policies established by the Indiana Health Coverage Programs (IHCP). The IHCP accomplishes required utilization review activities through a series of monitoring systems developed to ensure that services are reasonable, medically necessary, and of optimum quality and quantity. Both members and providers are subject to utilization review.

Utilization review activities ensure the efficient and cost-effective administration of the IHCP by monitoring the following areas:

- Billing and coding practices
- Diagnosis-related group (DRG) validations
- Documentation
- Medical necessity
- Misuse and overuse
- Other administrative findings
- Quality of care
- Reasonableness of prior authorization (PA)

The utilization review process assists the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) in making important policy decisions. In addition, utilization review activities can identify areas of policy that require clarification or change. It is a valuable tool in shaping policy guidelines to ensure that services are provided in an efficient and effective manner.

Program Integrity

> *Note: The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act with important requirements related to Medicaid program integrity, to help ensure that all aspects of the Medicaid program are strong and functioning well. Under Title VI, Chapter 3, of the DRA, entitled "Eliminating Fraud, Waste and Abuse," the U.S. Congress established the Medicaid Integrity Program (MIP) (Section 6034). Under the MIP, the Centers for Medicare & Medicaid Services (CMS) is statutorily required to develop a five-year Comprehensive Medicaid Integrity Plan. This plan, along with other information about combating Medicaid fraud, waste and abuse, is available on the Medicaid Integrity Program page at cms.gov.*

Title XIX of the *Social Security Act, Sections 1902* and *1903*, and regulations found in *Code of Federal Regulations 42 CFR 455* and *42 CFR 456* require that the IHCP agency be able to identify and, if warranted, refer cases of suspected abuse or fraud to the Indiana Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation and prosecution.

According to *42 CFR 456.3*, the Medicaid agency must implement a statewide surveillance and utilization control program that accomplishes the following:

- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments
- Assesses the quality of those services
- Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of *42 CFR 456*
- Provides for the control of the utilization of inpatient services in accordance with subparts C through I of *42 CFR 456*

The OMPP oversees a number of initiatives designed to ensure the integrity of the IHCP through the work of the Program Integrity staff. OMPP Program Integrity ensures that correct payments are made to legitimate providers for appropriate and reasonable services to eligible Medicaid members.

Potential fraud and abuse are identified by providers, members or public complaints received by Program Integrity or through the auditing process. In accordance with *42 CFR 455.2*, the following definitions are applied for fraud and abuse:

- *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that individual or some other person. It includes any act that constitutes fraud under applicable federal or state law. The following list contains select examples of fraud:
  - Altering a member's medical records to generate fraudulent payments
  - Billing for services or supplies that were not rendered or provided
  - Billing for more costly services than those that were rendered (upcoding)
  - 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 with medically necessary services
  - Misrepresenting services provided (for example, billing a covered procedure code but providing a noncovered service)
  - Billing more than the charge to the general public
  - Billing for services provided by unqualified or unlicensed personnel
  - Soliciting, offering or receiving a kickback, bribe or rebate from medical providers for referrals or use of a product or service
- *Abuse* means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for

services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. The following is a small list of examples of abuse:

- Rendering or ordering excessive services, especially diagnostic tests
- Submitting claims for services inconsistent with the diagnosis and treatment of the member
- Rendering or ordering medically unnecessary services
- Poor or unsatisfactory quality of care provided to a member
- Billing the member for remaining balance after Medicaid payment
- Violating any of the provisions of the provider agreement

Reporting Fraud and Abuse

Healthcare fraud and abuse affect everyone. The state of Indiana relies on the healthcare provider community to actively participate in detecting and deterring IHCP fraud and abuse. Any suspected fraud or abuse by IHCP members or providers should be reported to the OMPP Program Integrity staff by mail, telephone or email:

MS07
OMPP Program Integrity
402 W. Washington St., Room W374
Indianapolis, IN 46204

Toll-Free Telephone: 800-457-4515, Option 2
Email: Program.Integrity@fssa.in.gov

Individuals, such as IHCP members or employees of a provider, should contact Program Integrity with issues of suspected fraud and abuse so these issues can be documented, tracked and preliminarily investigated.

Referrals to the Medicaid Fraud Control Unit

In accordance with *42 CFR 455* and *Indiana Administrative Code 405 IAC 1-1.4-5*, if OMPP Program Integrity receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. Program Integrity will determine if there is a credible allegation of fraud (CAF). A CAF may be an allegation that has been verified by the state of Indiana, from any source, including but not limited to the Fraud hotline or claims data mining. Program Integrity refers all CAFs to Indiana MFCU for a full investigation for potential criminal or civil prosecution.

The MFCU is responsible for investigating whether the referrals initiated by Program Integrity require further investigation for potential criminal or civil prosecution. Such an investigation could result in a felony or misdemeanor criminal conviction. Providers under investigation by the MFCU are not identified until court action is filed in a county, state or federal court. The MFCU can also refer cases of providers convicted of IHCP fraud to the U.S. Department of Health and Human Services (HHS) for civil monetary penalties under the *Federal Civil Monetary Law* of the *Social Security Act*.

Fraud and Abuse Detection System

The Fraud and Abuse Detection System (FADS) team reviews claim data at the systems level and identifies aberrant billing patterns and inappropriate reimbursements that may occur across a specific provider type and specialty. The FADS process compares a provider's individual service provision with a peer group of similar specialty. Based on paid-claim information, FADS team establishes statistical profiles for provider peer-class groups to monitor the delivery and receipt of medical services. Analyzing and comparing providers with peer groups can identify misuse and aberrant practices. Trained FADS staff completes an analysis of utilization review data. When a potential issue is discovered, thorough research and payment

studies are performed to determine if an inappropriate payment occurred. Medical or other records, including X-rays, may be requested from the provider to explain the alleged inappropriate payment. Provider documentation must be sufficient to fully disclose and document the extent of the services provided. See the *Medical and Financial Record Retention* section for details.

All providers and members may be subject to review, fraud referral and administrative sanctions. Providers and members are notified in writing about the results of any utilization review that has resulted in administrative action. The written notification outlines the administrative action anticipated and includes administrative reconsideration and appeal procedures.

Providers should use the following mailing address to mail documentation for current audits, requests for administrative reconsiderations and other FADS-related correspondence:

Deloitte & Touche LLP
Salesforce Tower
111 Monument Circle, Suite 4200
Indianapolis, IN 46204

Email any questions to ProgramIntegrity.FSSA@fssa.in.gov.

Provider Responsibilities

IHCP providers are well positioned to help stop abuse of IHCP programs and reverse trends related to misuse and overuse of services and inappropriate billing practices. Providers that rely on billing services and other consultants should carefully monitor how the IHCP is being billed for services. Regardless of who submits the forms, providers are legally responsible for claims filed on their behalf.

Program Integrity identifies areas of noncompliance and misunderstanding related to IHCP billing, benefits and reimbursement. This information is disseminated to the IHCP provider community through IHCP provider publications, such as bulletins and banner pages. Program Integrity education and training presentations are available for providers on the *Program Integrity Provider Education Training* page at in.gov/medicaid/providers.

To keep informed of current communications and policy updates, providers must enroll in the IHCP Email Notifications (sign up to receive news and updates on the home page at in.gov/medicaid/providers). Providers that are already enrolled should verify that their email addresses on file are correct.

It is the responsibility of the provider to abide by the IHCP provider reference modules, which are updated periodically. Updates to policies or procedures that occur after the effective date indicated on the module are announced in provider bulletins, banner pages and news items. Any amendments to the provider modules, as well as provider bulletins, banner pages and news items shall be binding upon publication to the official Indiana Medicaid website at in.gov/medicaid/providers.

Billing IHCP Members

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for an IHCP-covered service. According to *42 CFR 477.15*, acceptance of IHCP payment in full is a condition of participation in the IHCP. For more information on charging IHCP members for noncovered services, see the *Provider Enrollment* module.

An IHCP provider can bill a member only when the following conditions have been met:

- The service to be rendered must be determined to be noncovered by the IHCP – for example, the member has exceeded the program limitations for a particular service or PA for the service was denied.
- The member must understand, **before receiving the service**, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service.

If the member has a primary medical provider (PMP) and wishes to receive services from a non-IHCP provider, the PMP must inform the member that services will not be covered and may include an additional out-of-pocket expense.

A generic consent form is not acceptable unless it identifies the specific procedure to be performed and the member signs the consent before receiving the service. If written statements are used, the statements must not contain conditional language such as, "If an IHCP service is not covered…."

Medical and Financial Record Retention

In accordance with *405 IAC 1-1.4-2,* all IHCP providers shall maintain medical and other records of services provided to IHCP members for a period of seven years from the date of service. These records must be of sufficient quality to fully disclose and document the extent of services rendered. The records must be documented at the time the services are provided or rendered, and prior to submitting the associated claim.

> *Note: If circumstances delay providers in documenting services (such as for dictation, transcribing or staff working off-site), the IHCP will allow for delay of a day or two if the reason is documented at the time the service is provided.*

405 IAC 1-1.4-2(b) also states that 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:

- The identity of the individual to whom service was rendered
- The identity, including dated signature or initials, of the provider rendering the service
- The identity, including dated signature or initials, and position of the rendering or ordering provider and the provider's employees rendering the service, if applicable
- The date on which the service was rendered
- The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only
- A detailed statement describing services rendered, including duration of services rendered
- The location at which services were rendered
- The amount claimed through Medicaid for each specific service rendered
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs
- When required under Medicaid rules, physician progress notes as to the medical necessity and effectiveness of treatment and ongoing evaluations to assess progress and redefine goals
- X-rays, mammograms, electrocardiograms, ultrasounds and other electronic imaging records

- Fully disclosed and documented extent of the services provided to the Medicaid member
- Medical necessity and justification for the treatment and clinical rationale

Additional, service-specific documentation requirements are specified in other IHCP provider reference modules, as well as in IHCP provider bulletins and banner pages, the *IAC*, and statutes.

Providers whose reimbursement is determined by the FSSA shall maintain financial records for a period of not less than three years following submission of financial data to the IHCP. A provider shall disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.

Upon request, providers must openly and fully disclose all medical, financial and other records maintained as described in this section. The request may come from but not limited to the OMPP, FSSA Audit Services, MFCU, CMS, HHS Office of Inspector General (OIG) or contractors of these entities. Failure to provide such records when requested may constitute an abuse of IHCP policy and a violation of federal law and of the provider agreement.

Recommended Best Practices

The OMPP Program Integrity Unit recommends the following best practices, based on findings and issues noted from prior audits:

- Make sure documentation is complete, concise, accurate and legible.
- Make sure documentation is signed and dated.
- Make sure documentation is in compliance with federal and state laws.
- Make sure documentation supports the most accurate and specific procedure and diagnosis codes that best describe the reason for the encounter and the service provided; also, use appropriate modifiers and units, per IHCP policy.
- Make sure documentation reflects all member and provider information.
- Make sure documentation reflects a qualified billing and rendering provider.
- Make sure documentation clearly identifies the rendering provider and/or rendering provider employees.
- Make sure documentation includes details of physician involvement.
- Document services during the encounter or as soon as practicable after the encounter.
- Develop and implement a medical record documentation policy if there is not one in place.
- Regularly check the medical record documentation policy to make sure that it complies with federal and state regulations.
- Regularly audit your medical records.
- With electronic health records (EHRs), some extra cautions may be needed:
  - Make sure all notes have a date and time stamp.
  - Recognize each visit as a standalone record and ensure documentation reflects the level of service provided.
  - Create policies and procedures to ensure documentation integrity.

Reporting, Returning and Explaining Overpayments

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 *U.S. Code 42 USC 1320a-7k(d) – Reporting and returning of overpayments* and *42 CFR 433 subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers.* 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 healthcare programs. A provider that fails to make the repayment within 60 calendar days of receipt of the final notification of overpayment notification may also be at risk from a "whistleblower" lawsuit.

IHCP providers should follow the procedures in the *Claim Adjustments* module to correct routine overpayments, including special instructions for submitting overpayment adjustments in cases where the claim has exceeded timely filing limits.

The IHCP has established a self-disclosure protocol for providers that need to report Medicaid and Children's Health Insurance Program (CHIP) fee-for-service, nonpharmacy overpayments. Providers should use the self-disclosure protocol to report the following, but not limited to, self-identified items:

- Provider billing system errors or issues that result in overpayments
- Potential violations of federal, state or local laws
- Potential violations of regulations
- Potential violations of billing, coding or other healthcare policies
- Overpayments involving specific compliance issues
- Overpayments involving cumulative amounts greater than $1,000
- Overpayments involving fraud or violations of law

> *Note: In the event a provider identifies a single claim, or a small number of claims, as erroneous, the IHCP recommends the provider void and (if applicable) resubmit the claim correctly through the IHCP claim-processing system.*
>
> *Errors or overpayments that are the result of issues with the IHCP claim-processing system should not be reported through this self-disclosure mechanism. Instead, providers should report such issues to the IHCP Provider and Member Concerns Line at 800-457-4515, option 8 for Audit Services.*
>
> *Additionally, this self-disclosure protocol should not be used to report managed care overpayments; instead, use the preceding phone number and option or contact the specific managed care entity (MCE) involved.*

To avoid overpayments being included in subsequent Program Integrity audits, providers should adjust their claims (if before timely filing) or request claim adjustments as soon as overpayments are identified by internal audit procedures.

Submitting Self-Disclosure Form and Supporting Documentation

To report self-identified overpayments to OMPP Program Integrity, providers must use the *Voluntary Self-Disclosure of Provider Overpayments Form*, available from the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* page at in.gov/medicaid/providers.

Providers must submit the self-disclosure form and supporting documentation either electronically through Secure File Transfer Protocol (SFTP) or by mail. No repayments should be made at the time of the initial

self-disclosure. Providers need to receive verification of the overpayment amount from IHCP Program Integrity before they submit any repayments.

The preferred method of submitting the self-disclosure form and supporting documents is via SFTP. Files containing claim information and all self-disclosure correspondence from all sections of the form are to be submitted via SFTP to ensure Health Insurance Portability and Accountability (HIPAA) compliance. The instructions and form for getting set up in SFTP are available from the *Protocol for Voluntary Self-Disclosure of Provider Overpayments* page at in.gov/medicaid/providers.

If the provider chooses to mail these files instead, care must be taken to submit documentation in a-HIPAA-compliant format via Certified Mail -to the following mailing address:

Audit and Overpayment
IHCP Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297

Providers must not mail documents without using appropriate encryption methods. Passwords to encrypted files must be provided via telephone or emailed separately from the documentation or data. Under no circumstances should protected health information (PHI) be sent unsecured, and never include Social Security numbers of Medicaid members.

Remitting Payments

Providers should not submit payment with the self-disclosure form. The IHCP must first review the provider's completed packet and validate the claims and overpayment amount. Before making any payment, the provider should wait for a letter that confirms the total amount owed. If the submitted form is complete and accurate, and depending on the number of claims to be validated, the confirmation letter is mailed typically within 14 business days. Incomplete forms and MCE disclosures will be returned by the IHCP, which could lead to referral for an audit.

After the IHCP reviews all disclosure submission material, the provider will receive notification indicating the final overpayment dollar amount and the procedure for remitting additional payment, if necessary. If submitting a check, be sure to note the audit number on the check. If the submitted claim data does not materially match the IHCP payment data, or if the IHCP does not accept the provider's self-disclosure results, the provider will receive correspondence with further instructions. Self-disclosure assumes that the provider has waived the right to administrative review and appeal.

Federal Exclusion From Program Participation

The HHS OIG has the authority to exclude individuals or entities that have been convicted of fraud from participation in Medicare, Medicaid and other federal healthcare programs. An exclusion applies to all state and federal healthcare programs. The OIG publishes names of excluded individuals and entities. Providers can access the Exclusions Database at oig.hhs.gov.

The following excerpt is from the 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.*

The following list (adapted from the same OIG *Special Advisory Bulletin*) provides examples of items or services reimbursed by federal healthcare programs that violate OIG exclusions when provided by excluded parties. These examples are not a complete list; however, they help illustrate why IHCP providers must screen potential employees and review all current employees for OIG exclusion:

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, if such services are reimbursed directly or indirectly by a federal healthcare program
- Services performed by excluded pharmacists or other excluded individuals (such as pharmacy technicians) who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any federal healthcare program
- Services performed by excluded ambulance drivers, dispatchers or other employees involved in providing transportation reimbursed by a federal healthcare program
- Services performed for members by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a federal healthcare program
- Services performed by excluded social workers who are employed by healthcare entities to provide services to members, and whose services are reimbursed, directly or indirectly, by a federal healthcare program
- Administrative services, including the processing of claims for payment, performed by an excluded individual and reimbursed by a federal healthcare program
- Services performed by an excluded administrator, billing agent, accountant, claim processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a federal healthcare program
- Items or services provided to a member by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a federal healthcare program
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of members and reimbursed, directly or indirectly, by a federal healthcare program

Providers are required to check all current and future employees, subcontractors and agency staff for possible exclusion from participation in federal healthcare programs. Failure to verify this information may result in recoupment, fines and exclusion from federal healthcare programs, including the IHCP.

Knowing submission of false claims in violation of the exclusion provisions may be prosecuted in state or federal court. Providers must ensure that they maintain and follow written internal procedures for compliance with federal exclusion guidelines. Providers are advised to self-report any violation of the federal exclusion policy to the MFCU by calling 800-382-1039.

Employee Education About False Claims Recovery

DRA Section 6032, Employee Education About False Claims Recovery, established *Section 1902(a)(68)* of the *Social Security Act*, which requires certain entities to provide *False Claims Act* education to their employees.

Employer Requirements

Section 1902(a)(68) of the *Social Security Act* reads as follows:

> A State plan for medical assistance must provide that any entity that receives or makes annual payments under the [Medicaid] 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 by sections 3729 through 3733 of Title 31 of the United States Code,
> - administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code,
> - 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 1128B(f).
>
> (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.

An entity is not required to create an employee handbook if one does not already exist. No template of policy language is being furnished to entities, as this detail should clearly relate to the entity's specific practices.

Compliance Reviews

DRA Section 6032 further identifies duties of the State to conduct reviews to assess provider compliance. The FSSA or its contractors will conduct reviews annually of selected entities. The reviews include collection and examination of the entities' policies and procedures regarding the education it provides to employees, management, officers, and contractors or agents, as set out in items (A) through (C) in the preceding section.

On request by the FSSA or its contractors, entities will provide a copy of the policies and procedures for review purposes. On request by the FSSA or its contractors, entities must provide a copy of the employee handbook, if one exists, for review purposes.

Consequences of Noncompliance

If an entity is found not to be in compliance with any part of the previous requirements regarding the *False Claims Act* and *Section 1902(a)(68)* of the *Social Security Act*, entities are required to submit to the FSSA a corrective action plan within 60 calendar days.

The corrective action plan describes the actions and methods the entity will follow to ensure that the entity comes into compliance. If an entity is required to submit a corrective action plan and does not do so within 60 days, the State may withhold payment to the entity until a corrective action plan is received. The

corrective action plan designates a contact person within the entity responsible for communicating details about plan implementation to the FSSA.

Provider Utilization Review

All IHCP providers are subject to ongoing Program Integrity activities. These activities identify areas of IHCP misuse, overuse, abusive practice patterns and potential fraud. Common trends in fraud, waste and abuse include, but are not limited to, the following situations:

- Billing and receiving payment from a member for IHCP-covered services
- Billing for medically unnecessary services not supported by the diagnoses documented
- Billing for services outside the scope of practice of the enrolled provider specialty
- Billing generic procedure codes when procedure codes specific to the services rendered are available
- Billing IHCP members more than private-pay patients
- Billing inaccurate units of service
- Maintaining inadequate or incomplete documentation to support the services billed
- Noncompliance with published IAC regulations
- Unbundling globally billed charges, such as surgical, laboratory, radiology and dental services
- Charging IHCP members for missed appointments
- Charging IHCP members for transfer or copies of medical records
- Manipulating service procedure codes for reimbursement

Providers are selected for utilization review based on complaints received by Program Integrity, data monitoring or on the results of the FADS monitoring process.

The objectives for utilization review activities are as follows:

- Assist in identifying and correcting patterns of documentation and billing problems for all IHCP providers.
- Assist in developing clear and consistent medical policies.
- Assess quality of care.
- Determine whether services provided and billed are consistent with IHCP guidelines.
- Educate the provider about any problems identified, when appropriate.
- Identify and initiate recovery of overpayment refund amounts due.
- Perform activities that evaluate medical services for appropriateness, reasonableness and necessity.
- Verify billed services.
- Recover inappropriate IHCP payments.
- Refer credible allegations of fraud to the appropriate investigative entity.

Utilization review of an IHCP provider can result in one or more of the following actions, depending on the review findings:

- Closure of the case because aberrant practices were not confirmed
- Formal request for further documentation from the provider
- Educational contact to correct minor infractions, such as:
  - A letter from the IHCP detailing the inappropriate action
  - A visit by a Provider Relations field consultant
  - A visit by Program Integrity staff to explain program guidelines related to medical necessity and intensity and appropriateness of service, or to assist with administrative aspects of the program
- On-site or in-house audit of medical records (see the *Program Integrity Audit Process* section)
- Recoupment of improper reimbursements due to incorrect billing, insufficient or missing documentation, or lack of medical necessity for services rendered (see the *Recoupment of Overpayment* section)
- Prepayment review of IHCP claims because of serious billing errors that show consistent lack of knowledge of IHCP rules, or lack of desire to abide by those rules (see the *Prepayment Review* section)
- Referral for possible administrative sanctions for continuing noncompliance
- Referral to the MFCU for further investigation and possible criminal or civil prosecution (see the *Referrals to the Medicaid Fraud Control Unit* section)

The main focus of provider utilization reviews, including on-site and in-house medical record audits, is to evaluate utilization and recover overpayments.

Program Integrity Audit Process

Program Integrity conducts retrospective audits of IHCP providers to evaluate and document patterns of healthcare provided to members, as well as to ensure compliance with IHCP guidelines, identify instances of underpayments and recover any overpayments.

Cases are developed and documented through research and review of the following types of items:

- Audit reports
- Claim samples
- Case files and prior reviews for background information
- Current regulations and laws pertinent to the review, as well as historic regulations and laws in place during the applicable review period
- Medical records
- Referrals

In accordance with *405 IAC 1-1.4-9*, the IHCP limits its audit to claims submitted and paid by the IHCP during the appropriate look-back period, as follows:

- Except as indicated later in this section, the audit look-back period for audits initiated on or after July 1, 2019, shall be three years and 180 days.
- The audit look-back period accounts for and includes the timely filing period described in *405 IAC 1-1-3* for determining the available audit dates.
- The look-back date begins on the date of audit initiation or when the IHCP discovers a credible allegation of fraud or abusive billing practices, whichever is earliest.

After the IHCP begins its audit, all claims within the audit look-back period remain viable for audit and recoupment throughout the audit and appeal process. If the IHCP discovers information that may indicate a credible allegation of fraud or abusive billing practices, or a claim-processing error rate greater than 30%, it may increase the audit look-back period from three years and 180 days to seven years.

The Program Integrity audit process involves the following steps, explained in detail in the subsections that follow:

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. *Provider Intent Form – Reconsideration and Appeal Waiver* (PIF-RAW) and optional administrative reconsideration process
6. *Final Calculation of Overpayment* (FCO) letter or *Final Audit Findings* (FAF) letter
7. Administrative appeal process (optional)
8. Recoupment of overpayment (if applicable)

Audits may be conducted unannounced, with limited notice, or without an initial request for records.

Preliminary Review of Provider Billing, Payment and Audit History

The preliminary review involves identification and analysis of the provider enrollment history and claim data to look for patterns of possibly aberrant activity. Additionally, Program Integrity looks to compare the provider with peers of like specialty to identify potential outlier activity. A review of any past audit history serves to identify any previous areas of concern identified during another audit. Program Integrity meets with subject-matter experts in the OMPP and the FADS team to review the data and analysis, and to recommend an action based on the preliminary review findings. During this time, Program Integrity coordinates and vets recommended action with the MFCU. Finally, the FADS team initiates the recommended action approved by Program Integrity.

Request of Medical Records from Provider

A *Notice of Audit & Request for Records* letter is sent, via certified mail, to the provider's *mail-to* address on file with IHCP Provider Enrollment. Claims chosen for review or audit can be identified either on a claim-by-claim basis or as a result of a statistically valid random sample (SVRS) to be extrapolated to the full claims universe selected.

The audit notification letter details specifically what documentation is requested for submission to facilitate the review. Requested records may be submitted in hard copy or electronically through a secure web portal set up by the FADS team. Costs for copies of medical records are not absorbed by the FSSA or any of its contractors.

Providers are given 30 days to submit the requested documents for review (extensions can be granted when requested in writing by the provider). The FADS team will follow up with providers if no response to the audit notification letter is received.

On-site or In-House Medical Record Audit

Medical record audits may be conducted at the provider's office (on-site) or remotely (in-house) using copies of medical records that were sent in response to the mailed request.

During the audit process, the Audit team reviews IHCP policies, coding regulations, and all other state and federal rules **pertinent to the dates of service**. The Audit team does not apply current regulation and requirements to historic claims.

The Audit team uses the following criteria when reviewing records:

- The medical record or documentation must support the services billed.
- Services must be covered IHCP benefits.
- Services must be medically reasonable and necessary, as indicated by the documentation in the medical record.
- Services must be billed in the quantities ordered and documented, as indicated by the documentation in the medical record.
- Services must be specifically identified on the provider's itemized statements, or the charge tickets maintained by the provider.
- Services must be billed to the IHCP only after other medical insurance resources have been exhausted.
- Services must be billed in accordance with established IHCP policy.
- The physician must order services in writing, as indicated by the documentation in the medical record.

Statistically Valid Random Samples

Provider audits may be conducted using an SVRS of the provider claims or a focused sample, which may be an SVRS, concentrating on one or more specific issues. When the audit is performed on an SVRS of claims, the findings can be extrapolated to the total claim population for recovering overpayments. For example, during an on-site audit, $2,000 was identified as an inappropriate IHCP payment in an SVRS of 100 claims. The total population for the audit time period was 350 claims. To reach the extrapolated overpayment, the actual overpayment is divided by the number of claims in the random sample and then multiplied by the total claims in the population: $2,000/100 × 350 = $7,000.

Under *Indiana Code IC 12-15-21-3(5)*, the FSSA and its contractors may determine the amount of overpayment made by a provider by means of a random sample and extrapolation audit. The FSSA and its contractors shall conduct the random sample and extrapolation audit in accordance with generally accepted statistical methods and shall base the selection criteria on a random sampling methodology generally accepted by the statistical profession.

In accordance with *405 IAC 1-1.4-9(g)*, in the event that the provider wishes to appeal the accuracy of the random sampling methodology, the provider may do one of the following:

- Present evidence to show that the sample used by the FSSA or its contractors was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.
- 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 FSSA or its contractors, or an audit of 100% of medical records of payments received during the audit period. Any such audit shall:
  - Be completed within 180 calendar days of the date of appeal.
  - 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, subject to review and approval by the FSSA or its contractors, to demonstrate this compliance.

On-site Audits

The main focus of the on-site visit is to gather requested documents as well as open communication with the provider to ensure a smooth audit process. Program Integrity staff typically confirms scheduled audits by certified mail subsequent to telephone scheduling; however, audits may be conducted unannounced or with limited notice based on concerns in the identification and development of the case. Providers are typically notified in writing of the results of the audit and any corresponding actions.

To maintain privacy and provider accountability for record security, Program Integrity allows a representative of the provider's office to be present during the on-site audit of the records. However, the following conditions apply:

- Provider office staff can remain with the Audit team only to ensure security and physical integrity of the records. Remaining with the Audit team is an option for providers, not a requirement.
- Provider office staff can serve as a resource to the Audit team by answering questions raised by the Audit team or by retrieving missing documentation, when requested.
- Provider office staff will not be involved in the audit process and should not attempt to interfere with the record review process.
- Providers are reminded that audit findings at the point of record review are preliminary and, therefore, no argument or challenges are appropriate.

If a provider's record security procedures would preclude auditors from reviewing original records without provider staff present, the provider may exercise one of the following options when notified of an upcoming audit:

- Appoint a staff member to remain present during the on-site audit of records to ensure the security of original medical records.
- Provide copies of the medical record to be reviewed during the on-site audit, with original medical records being available for audit staff to review as requested.

The provider is not required to exercise any of these options. Providers may continue to allow auditors to review the original medical records. Any copies can be made at the time of the audit. Costs for copies of medical records are not absorbed by the FSSA or any of its contractors.

Draft Audit Findings Letter of Preliminary Audit Results

If Program Integrity believes that an overpayment has occurred, Program Integrity may submit to the provider, via certified mail, a preliminary *Draft Audit Findings* (DAF) letter outlining the claims that may have been billed inappropriately. The specific federal, state, IHCP, or coding rules and regulations related to the findings are detailed in the letter, as well as whether the audit findings are the result of a claim-specific review or a random-sample audit.

The DAF letter explains that the provider has the option to dispute the draft audit findings by submitting a *Request for Administrative Reconsideration* (RAR). Included with the DAF letter is a *Provider Intent Form – Reconsideration and Appeal Waiver* (PIF-RAW).

Provider Response and Optional Administrative Reconsideration Process

The provider is required to indicate, through completion of the *Provider Intent Form – Reconsideration and Appeal Waiver* (PIF-RAW), included with the DAF letter, whether they agree with the findings and wish to receive the final calculation of overpayment or to request administrative reconsideration.

If a provider wishes to dispute the draft audit findings, the provider ***must*** first request administrative reconsideration by returning the PIF-RAW with the option for administrative reconsideration clearly indicated. Supporting documentation and comments must be submitted with the PIF-RAW before the administrative reconsideration can begin. The administrative reconsideration process must be complete before filing an administrative appeal. A provider can submit a *Request for Administrative Reconsideration* (RAR) within 45 days after the issuance of the preliminary review of DAF per *IC 12-15-13-3.5* for noninstitutional providers or *IC 12-15-13.4* for institutional providers:

- If an RAR is not submitted within 45 days after issuance of the DAF letter, the preliminary draft audit findings will not be reconsidered, and the provider may forfeit certain rights available to providers under Indiana law.

- If a provider submits a request for reconsideration within 45 days, Program Integrity may reconsider its findings based on any evidence presented by the provider. The provider must submit comments, as well as additional supporting documentation, with the request for administrative reconsideration.

The reconsideration process facilitates a path of open dialogue between the provider and Program Integrity.

After the reconsideration process has concluded, Program Integrity sends the provider a *Response to Request for Administrative Reconsideration* (RARR) letter with a new PIF-RAW form. The provider can either agree to the audit findings or submit additional requests for administrative reconsideration, as outlined in the letter and PIF-RAW.

Final Calculation of Overpayment Letter or Final Audit Findings Letter

After the PIF-RAW has been signed and returned with the indication that the provider agrees with the findings – or if the provider fails to return the PIF-RAW, either in response to the DAF or to a subsequent RRAR – the provider will receive one of the following letters:

- *Final Calculation of Overpayment* (FCO) – The FCO letter identifies the amount (including the alleged overpayment and any applicable interest owed on that overpayment) that must be repaid to the state of Indiana. The FCO letter gives explanation of program noncompliance resulting in overpayments, as well as claim-specific details. The FCO letter also explains the provider's right to appeal the finding and the process the provider must follow to maintain and utilize the right to appeal.
- *Final Audit Findings* (FAF) – If no overpayment is identified as a result of the audit, or at the conclusion of administrative reconsideration, a FAF letter is sent to notify the provider of the results and close the audit process.

Administrative Appeal Process

Findings in the FCO letter may be appealed; however, the provider ***must*** request administrative reconsideration before filing an administrative appeal. The appeals process is set in sections 10 through 13 of *405 IAC 1-1.4*.

The provider may appeal the findings through the Office of the Secretary of the FSSA within 60 calendar days of the receipt of the FCO letter received in response to an RAR. The provider must file a statement of issues within 60 calendar days after the receipt of the FCO letter or at the time the provider files a timely request for appeal, whichever is later. Requirements for the statement of issues are set in *405 IAC 1-1.4-11(j)* through *11(o)* for noninstitutional providers and *405 IAC 1-1.4-12(k)* for institutional providers.

The provider must submit the appeal and statement-of-issues documentation to the following address:

MS07
Secretary Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 W. Washington St., Room W374
Indianapolis, IN 46204-2739

Recoupment of Overpayment

405 IAC 1-1.4-9 states that, under *IC 12-15-21-3(5)* and *IC 12-15-21-3(7)*, the IHCP may recover payment from any provider for services rendered to an individual, or claimed to be rendered to an individual, if the IHCP, after investigation or audit, finds any of the following:

- The services paid for cannot be documented by the provider as required by *405 IAC 1-1.4-2*.
- The amount paid for such services has been paid from other sources or is subject to third-party liability.

- The services were provided to a person other than the person in whose name the claim was made and paid.
- The service reimbursed was provided to a person who was not eligible for Medicaid at the time of the provision of the service.
- The paid claim arises out of any act or practice prohibited by law or by rules of the FSSA.
- The overpayment resulted from one of the following:
  - An inaccurate description of services or an inaccurate usage of procedure codes, revenue codes and modifiers
  - The provider's itemization of services rather than submission of one billing for a related group of services provided to a member (global billing) as set out in the IHCP's medical policy
  - Duplicate billing
  - Claims for services or materials determined to have been not medically reasonable or necessary
  - Any other reason not specified

As required by *42 CR 433*, the IHCP must refund the federal share of any Medicaid overpayment back to the federal government.

If the IHCP determines that an overpayment has occurred, the IHCP shall notify the provider by certified mail. A provider that receives a notice may elect to do one of the following:

- Repay the amount of the overpayment pursuant to *IC 12-15-13-3.5(e)* for a noninstitutional provider or *IC 12-15-13-4(e)* for an institutional provider.
- Request a hearing and repay the amount of the alleged overpayment pursuant to *IC 12-15-13-3.5(e)* for a noninstitutional provider or *IC 12-15-13-4(e)* for an institutional provider.

The IHCP shall initiate recoupment proceedings to collect any overpayment that is not repaid within 300 calendar days after the provider's receipt of the FCO letter, per *405 IAC 1-1.4-11(d)* or *405 IAC 1-1.4-12(e)*. The IHCP may recoup an overpayment until it is satisfied through any of the following methods:

- Offset the amount of the overpayment against current Medicaid payments to a provider.
- In the case of an institutional provider, offset the amount of the overpayment to any or all of the Medicaid facilities owned by the provider.

> *Note: Although IC 12-15-13-3.5(e) requires providers to repay the amount of the final calculation within **300 days** of the FCO letter, providers should be advised that, under federal law, a provider that identifies an overpayment must report the overpayment and return the entire amount to a Medicaid program within **60 days** after it is identified. 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. The FSSA will accept repayments made within 60 calendar days of the provider's receipt of the FCO letter. For more information, see the Reporting, Returning and Explaining Overpayments section.*

The FSSA shall assess an interest charge in addition to the amount of overpayment identified in the notice of overpayment. Such interest charge shall not exceed the percentage set out in *IC 12-15-13-3.5(g)* for a noninstitutional provider or in *IC 12-15-13-4(h)* for an institutional provider. Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. Under *IC 12-15-21-3(6)*, the interest shall:

- Accrue in one of these ways:
  - From the date of the sample claim(s) paid date through the date of the FCO letter to the provider
  - For extrapolated overpayments, from the last paid date of the audit period
- Apply to the net outstanding overpayment during the periods in which such overpayment exists.

- Be assessed even if the provider repays the overpayment to the IHCP within 30 days after receipt of the notice of the overpayment.

Providers can choose to have overpayment satisfied through accounts receivable against future payments or to submit payment by check to the following address:

Audit and Overpayment
IHCP Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297

Payments to the Provider

As specified in *405 IAC 1-1.4-9(e)*, underpayments discovered by the IHCP in the course of an audit shall be accounted for as follows:

- The sum of such underpayments shall reduce the sum of overpayments identified in the audit.
- The provider, at its own expense, may elect to examine the claims under audit for underpayments. If the provider identifies underpayments, then the sum of those underpayments, if verified by the IHCP, shall reduce the sum of overpayments identified.
- Underpayments shall only reduce overpayment findings.

If the FSSA recovers an overpayment to a provider that is subsequently found not to have been owing to the FSSA, either in whole or in part, then the FSSA shall pay to the provider interest on the amount erroneously recovered from the provider. Such interest shall accrue as follows:

- From the date that the FSSA recovered the overpayment until the date the overpayment is restored to the provider
- At the rate of interest that shall not exceed the rate set out in *IC 12-15-13-3.5(g)* for a noninstitutional provider or *IC 12- 15-13-4(h)* for an institutional provider

For hospitals that receive a notice that the provider has been underpaid by the FSSA as a result of the cost settlement process, the FSSA shall pay interest to the hospital on the amount of the underpayment beginning on the date of the underpayment at the rate outlined *405 IAC 1-1.4-9(e)(2)*.

Prepayment Review

According to *405 IAC 1-1.4-7(a)*, prepayment review (PPR) is a manual claims review process that allows for review of claims for appropriate coding and documentation as well as education on appropriate billing practices. PPR review of claims is not a sanction and is not subject to appeal. Providers may be added to or removed from PPR at the discretion of OMPP Program Integrity, as supported by *405 IAC 1-1.4-7(b)*. PPR ensures reimbursement for services is reasonable, medically necessary, and of optimum quality and quantity by reviewing claims and documentation *prior* to reimbursement. As part of the PPR process, providers are required to include supporting documentation for each claim submission in accordance with *405 IAC 1-1.4-7 (c)*. If the supporting documentation is not submitted, the claim will be denied.
During the review period, PPR staff conduct a review to confirm the following:

- Services were provided according to Medicaid policy requirements.
- The billed services were medically necessary, appropriate and not in excess of the member's need pursuant to a physician order as documented in policy or services standards.
- The number of visits and services delivered are logically consistent with the member's characteristics and circumstances, such as type of illness, age, gender and service location.
- The provider and member were Medicaid-eligible on the date the service was provided.

- Prior authorization was obtained if required by policy.
- The provider's staff was qualified as required by state or federal law.
- The provider possessed the proper license, certification or other accreditation requirements specific to the provider's scope of practice and Medicaid policy at the time the service was provided to the member.
- The claim does not duplicate or conflict with one reviewed previously or currently being reviewed.
- The payment does not exceed any reimbursement rates or limits in the Medicaid State Plan.
- Third-party liability within the requirements of *42 CFR 433.137* is appropriately billed and accounted for.

Note: Crossover claims from Medicare are excluded from PPR.

Prepayment Review Process Requirements

The PPR shall be implemented for a period of six months, unless a provider is terminated from the IHCP within this six-month period for actions outside of PPR. The six-month period begins upon the first successful adjudication of a claim submission under prepayment review.

The provider may be removed from the PPR process before the six-month deadline, at the discretion of the IHCP, if **both** requirements of *405 IAC 1-1.4-7(e)(1)* are met:

- The provider has achieved an 85% or more approval rate on claim submission for three consecutive months.
- The volume of the provider's claim submissions remained within 10% of its volume before they were placed on PPR.

If the provider does not meet the requirements in *405 IAC 1-1.4-7(e)(1)* by the end of the six-month period, the provider shall remain on prepayment review for an additional period of six months, and may be required to submit a corrective action plan.

If, after the second six-month interval, the provider fails to satisfy the requirements in *405 IAC 1-1.4-7(e)(1)*, the IHCP may do the following:

- Deny payment for medical assistance services rendered during a specified period of time.
- Terminate the provider agreement.
- Require a corrective action plan.
- Impose other sanctions as provided in section 4 of this rule.

In accordance with *405 IAC 1-1.7-7(f)*, if a provider has been on prepayment review for 12 months, the IHCP may terminate the provider agreement if there has been no billing activity for six consecutive months or the volume of its claim submissions during the review period was not within 10% of its volume before prepayment review.

Release from Prepayment Review

In accordance with *405 IAC 1-1.4-7(b)*, providers released from PPR may be subject to future follow-up reviews to ensure continued compliance with the IAC; any other applicable rules and regulations; and all rules and guidelines set forth in the *IHCP Provider Reference Modules* and all other IHCP publications, including, but not limited to, bulletins and banner pages.

Communications with Prepayment Review

For any questions or concerns regarding the PPR process, providers can call the IHCP Provider and Member Concerns Line at 800-457-4515, Option 7.

Claim Submission during Prepayment Review

During the period of time that a provider is on PPR, claims and documentation should continue to be submitted to Gainwell Technologies, the FSSA fiscal agent, according to existing procedures. All claim submissions must be compliant with all rules and guidelines set forth in the IHCP provider reference modules, bulletins and banner pages issued by the FSSA; the IAC; and any other applicable rules and regulations. Each claim submission must include documentation to support the reason for billing to the IHCP, as follows:

- Paper claim forms should be submitted by mail to the appropriate address listed in the *IHCP Quick Reference Guide*, along with required documentation, photocopied as single-sided pages.
- For instructions regarding the submission of attachments for electronic claims, see the *Claim Submission and Processing* module.

For reimbursement consideration, the IHCP reminds providers that initial fee-for-service claims filed after 180 days of the date of service (or date of discharge for inpatient claims) shall be denied for payment unless a waiver has been granted. This policy is compliant with the provisions set forth in *405 IAC 1-1-3*.

See the *Claim Submission and Processing* module for exceptions to the timely filing limit, as well as general information about claim-filing procedures. See the *Claim Adjustments* module for information about adjustments (voids and replacements) for paid claims.

Claim Adjudication by Prepayment Review

Claims received from providers while on PPR are suspended while the PPR staff adjudicates the claim. The majority of claims are adjudicated within 60 days; however, some claims may exceed the 60-day time frame because of unforeseen circumstances. This 60-day time frame does not include the 30 days that Gainwell uses to receive and process claims before forwarding them to the PPR staff.

Based on the PPR criteria and compliance with IHCP guidelines, a payment determination is made, and the provider is reimbursed or denied payment based on the determination. The provider's organization receives regularly scheduled Remittance Advice (RA) statements, which reflect claim payment or denial, as well as specific reasons for denial, on a claim-by-claim basis.

The PPR uses, but is not limited to, the following resources to ensure that reviews are conducted in a fair manner:

- IHCP billing guidelines as stated in the IHCP provider reference modules
- National Uniform Billing Guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®[1]) guidelines
- American Dental Association (ADA) Dental Procedure Codes (CDT)[2]
- *ICD-10-CM Official Guidelines for Coding and Reporting*, or its successor
- Industry standard utilization management criteria and care guidelines
- National Uniform Billing Committee (NUBC) *Official UB-04 Data Specifications Manual*

[1] *CPT copyright 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

[2] *CDT copyright 2022 American Dental Association. All rights reserved. CDT is a registered trademark of the American Dental Association*

- American Hospital Association (AHA) Coding Clinic guidelines
- Chargemaster guidelines as they relate to and define services billed
- Any other generally accepted industry standard guidelines

These resources are widely acknowledged as national guidelines for billing practices and support the concept of uniform billing for all payers. A healthcare provider's order must be present to support all charges, along with documentation to support the diagnosis and services or supplies that were billed. If there is no specific rule or policy related to a charge in question or a participation agreement does not exist, the PPR team will employ these guidelines.

Prepayment Review Claim Status – Remittance Advice

Per *405 IAC 1-1.4-8*, the IHCP may deny payment to any provider for Medicaid services rendered, including materials furnished to any individual or claimed to be rendered or furnished to any individual, if, after investigation by the IHCP, the IMFCU or other governmental authority, the IHCP finds any of the following:

- The claims were made for services or materials determined by the IHCP, the IMFCU or other governmental authority as not medically necessary.
- The amount claimed for such services or materials has been paid from other sources or is subject to third-party liability.
- The services claimed were provided to a person who was not eligible for Medicaid at the time of the provision of the service.

The decision as to denial of payment for a particular claim or claims is at the discretion of the IHCP. This decision shall be final and:

- Shall be effective on the date the provider is notified of the denial
- May be administratively appealed as described in the *Prepayment Review Claim Administrative Review and Appeals* section

For information on the status of submitted claims, providers should review the Remittance Advice (RA), which can be accessed through the provider's registered IHCP Provider Healthcare Portal (Portal) account. Providers can also elect to receive electronic RAs transmitted via 835 transaction. RAs for submitted claims are posted weekly on Tuesdays. Additional information about the RA can be found in the *Financial Transactions and Remittance Advice* module. If providers have further questions about the RA, they can contact Customer Assistance at 800-457-4584.

Prepayment Review Claim Administrative Review and Appeals

If a provider disagrees with the IHCP determination of payment, before filing an appeal with FSSA, the provider must first exhaust the administrative review process. Claim reimbursement administrative review procedures are outlined in *405 IAC 1-1-3*. Provider appeals, including claim reimbursement appeals, are conducted in accordance with *405 IAC 1-1.4-11* for noninstitutional providers and *405 IAC 1-1.4-12* for institutional providers.

The formal administrative review request must be filed within 15 days of notification of claim payment or claim denial. Requests for administrative review of claim determinations made during the PPR period must be sent, along with attached pertinent documentation, to the following address:

MS07
IHCP Provider Claim Administrative Reviews – Prepayment Review
Indiana Family and Social Services Administration
402 W. Washington St., Room W374
Indianapolis, IN 46204-2739

If the provider still disagrees with the claim determination after exhausting all the procedures required for an administrative review, the provider can request an appeal. The appeal must be filed within 15 days of receipt of the final administrative review decision. For claims that were originally submitted while under PPR, the mailing address for appeals is as follows:

MS27
IHCP Provider Claim Appeals – Prepayment Review
FSSA Office of General Counsel
402 W. Washington St., Room W451
Indianapolis, IN 46204

The same general procedures for claim administrative review and appeals described in the *Claim Administrative Review and Appeals* module apply during the PPR process.

Targeted Probe and Educate

Effective Aug. 21, 2021, the IHCP implemented the Targeted Probe and Educate (TPE), a program designed by the Centers for Medicare & Medicaid Services (CMS) to reduce costs related to improper payments. The program will also reduce provider burden through reviewing a smaller number of claims. This program allows the Program Integrity staff to educate providers with early intervention to reduce high levels of denied claims as well as reduce the risk of fraud, waste and abuse.

Based upon data analysis, Program Integrity will target providers most likely submitting noncompliant claims. The data analysis will identify common errors, denials, provider billing problems, prior investigations and audit reviews. This TPE program is designed to efficiently use medical record review processes and education through identification of providers that could best benefit from targeted review and education. Providers should note that identified errors within the targeted review will not be subject to recoupment during the TPE process.

TPE Process

The TPE process consists of the following:

- Notification and review:
  - Providers will receive a letter notifying them that they have been chosen for TPE.
  - The letter will explain what documentation is being requested, how to submit the documentation and any other information required to conduct the targeted review.
  - Upon receipt of the requested documentation, Program Integrity will review the documentation, applicable laws and policies, and coding requirements, then determine the most appropriate way to bill for the services.
- First round of reviews:
  - Providers will receive a letter with the results of the first round of reviews including education on the results.
  - After this first round of reviews, one of the following will occur:
    - If the provider passes with an 85% or higher accuracy rate, the provider will not go on to the next round and will be removed from TPE.
    - If the provider fails to meet an 85% or higher accuracy rate, the provider will be given at least a 45-day period to make changes and improve with the education provided.
    - If the provider failed to respond or participate in the TPE process, the provider may be subject to the following actions:
      - Audit
      - Prepayment review
      - Administrative sanctions

- Second round of reviews:
  - Providers will be moved to the second round of review if they do not meet an 85% or higher accuracy rate on the first review round.
  - Results from the second round of reviews will be communicated to the provider and will include the information from round one.
  - After this second round of reviews, one of the following will occur:
    - If the provider passes with an 85% or higher accuracy rate, the provider will not go on to the next round and will be removed from TPE.
    - If the provider fails to meet an 85% or higher accuracy rate, the provider will be given at least a 45-day period to make changes and improve with the education provided.
    - If the provider failed to response or participate in the TPE process, the provider may be subject to one or more of the following actions:
      - Audit
      - Prepayment review
      - Administrative sanctions
- Third round of reviews:
  - Providers will be moved to the last round of review if they did not meet an 85% or higher accuracy rate on the second review round.
  - Results from the third round of reviews will be communicated to the provider and will also include the information from rounds one and two.
  - After this third round of reviews, one of the following will occur:
    - If the provider passes with an 85% or higher accuracy rate, the provider will be removed from TPE.
    - If the provider fails to meet an 85% or higher accuracy rate by the third and final round or the provider refused to participate, then the provider may be subject to one or more of the following actions:
      - Audit
      - Prepayment review
      - Administrative sanctions

If providers successfully complete the TPE program, they will not be selected for TPE for at least one year. The goal is for providers to learn from education and improve their claim review results in the next "round of review" with no errors or a low error rate classification.

Program Integrity previously released a webinar that is available for providers to view that presents additional details and information. Providers can access the TPE webinar and other training materials from the *Program Integrity Provider Education Training* page at in.gov/medicaid/providers. If providers have questions, they are encouraged to email ProgramIntegrity.FSSA@fssa.in.gov.

Payment Error Rate Measurement Audits

The *Improper Payments Information Act of 2002* (IPIA), amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)* and the *Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)*, requires the heads of federal agencies to perform the following oversight activities for the programs they administer:

- Conduct an annual review of programs
- Identify those that may be susceptible to significant improper payments
- Estimate the amount of improper payments
- Submit those estimates to Congress
- Submit a report on corrective actions the agency is taking to reduce improper payments

The IPIA directs federal agencies, in accordance with Office of Management and Budget (OMB) guidance. The OMB has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant erroneous payments.

The CMS developed the Payment Error Rate Measurement (PERM) program to measure the accuracy of Medicaid and CHIP enrollment, as well as payments for services rendered to members. States are reviewed on a rotating three-year schedule. The PERM review period has been adjusted from a federal fiscal year (FFY) to a review year (RY) to review payments made from July through June to align with state fiscal years and to provide additional time to complete the cycle before reporting improper payment rates. The RY2024 CMS PERM audit began in 2022 and will examine claims paid between July 1, 2022, and June 30, 2023.

The Medicaid and CHIP programs are reviewed separately in three areas:

- Fee-for-service claims
- Managed care claims
- Program eligibility

For more information about PERM, see the *Payment Error Rate Measurement (PERM)* page at cms.gov.

PERM Review Responsibilities

Three federal contractors share responsibilities to conduct a review of the Medicaid and CHIP fee-for-service claims and managed care claims. Responsibilities are divided in the following manner:

- Statistical contractor (SC) – Responsible for selection of claim sample and conducting the calculation of the claim error rates
- Review contractor (RC) – Responsible for the collection of medical policies and for conducting the medical reviews and claim adjudication reviews
- Eligibility review contractor (ERC) – Responsible for performing eligibility reviews and providing eligibility data to support the RC data processing review

States and providers assist the federal contractors in gathering the data and providing medical record documentation for the review of the claims. If the states disagree with the contractor determinations, the CMS has outlined a process for states to resolve disagreements within prescribed limits.

Medical Record Collection Process

The RC conducts reviews of selected Medicaid and CHIP claims to determine if the claims were paid correctly. If a claim is selected in the sample for a service that the provider rendered to a Medicaid or CHIP member, the RC contacts the provider directly for a copy of the provider's medical records to support the medical review of the claim.

Before requesting records, the RC verifies providers' contact information. **It is important that the provider enrollment information on file with the IHCP be current.** Providers can view and update their enrollment information using the Provider Maintenance link in the IHCP Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers. For more information about updating provider information, see the *Update Your Provider Profile* page at in.gov/medicaid/providers.

The RC customer service representatives will validate provider contact information and inquire whether they prefer to receive the request for medical records by fax or U.S. mail. The initial medical record request packet to be sent to providers includes:

- CMS letter (authority to request records)
- PERM fax cover sheet with specific list of requested documentation (unique to each claim category)

- Claim summary data for the specific claim sampled
- Medical record submission options and instructions

After receiving the initial request packet for medical records, **the provider must submit supporting medical records electronically or via hard copy within 75 calendar days**. The RC or state staff follows up with the provider at regular intervals to ensure that the requested information is submitted on time. Patient authorization to release documentation is not required. Providers do not receive reimbursement for responding to a PERM request for medical records.

Past results have shown that the primary cause for errors during the medical review is insufficient or no documentation submitted for review. Sending incomplete documentation and not sending documentation are errors that can easily be prevented. The FSSA therefore requests that providers submit complete information before the 75-day deadline.

Any documentation requested from providers that is not received by the RC for review is considered an error against a state's Medicaid or CHIP program. For any incomplete documentation requests made by the RC, providers are given 14 calendar days to send the required documentation. The timeline provided will not be extended, and this error cannot be disputed with the RC. **If federal financial participation (FFP) is disallowed for a claim or a portion of the claim due to a lack of records from the provider, that amount is recovered from the provider by the IHCP**.

Protected Health Information Concerns

Providers should submit documentation using the methods described by the RC. Understandably, providers are concerned with maintaining the privacy of patient information. Remember that providers are required by *Section 1902 (a)(27)* of the *Social Security Act* to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish the CMS with information, including medical records, regarding any payments claimed by the provider for rendering services. In addition, the collection and review of protected health information (PHI) contained in individual-level medical records for payment review purposes is permissible by the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) and implementing regulations at *45 CFR 160* and *45 CFR 164*.

Contact Information

The RC furnishes contact information directly to providers. Communication with the RC and with the State OMPP PERM team is encouraged.

The OMPP PERM team can be contacted as follows:

MS07
FSSA Office of Medicaid Policy and Planning
Indiana Medicaid PERM Project
402 W. Washington St., Room W374
Indianapolis, IN 46204

Telephone: 800-457-4515, Option 8
Email: PERM@fssa.in.gov

Indiana Recovery Audit Contractor Program

Section 6411(a) of the *Affordable Care Act* amended section 1902(a) (42) of the *Social Security Act* to require that states and territories establish Medicaid Recovery Audit Contractor (RAC) programs. States that have not received an exemption from the CMS are required by statute to contract with one or more RACs to identify overpayments and underpayments and to recover overpayments from Medicaid providers. The RAC program's mission is to identify and correct improper Medicaid payments through the collection of overpayments and identification of underpayments made on claims for healthcare services provided

to Medicaid beneficiaries. The program enables the CMS to implement actions that will prevent future improper payments in all 50 states. The RAC program serves to complement the utilization review activities of the Indiana program integrity efforts.

Long-Term Care RAC Audits

Indiana FSSA Audit team conducts RAC audits of providers enrolled as provider type 03 – *Extended Care Facility*, which includes the following specialties:

- 030 – Nursing Facility
- 031 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- 032 – Pediatric Nursing Facility
- 033 – Residential Care Facility
- 034 – Psychiatric Residential Treatment Facility (PRTF)

LTC RAC audits are conducted on a two-year cycle.

The audits include a comprehensive review of financial activity for Medicaid-enrolled residents in all IHCP nursing facilities. Each audit covers a three-year review period adjusted by a one-year look-back period from the date when the audit commences. Because claims filed within the most recent 12 months are excluded (due to timely filing allowances), audited claims can date back four years.

The RAC audits focus on, but are not limited to:

- Payments made for dates of service after date of discharge
- Duplicate Medicaid payments
- Appropriateness of reporting Medicare or other third-party payments
- Errors related to patient liability application or collection

Limits Set on Medical Records Requests

The FSSA has set medical record request limits for RAC audits of provider type 01 – *Hospital*. These limits apply exclusively to Medicaid RAC audits of inpatient acute care hospitals only.

The request limits follow these guidelines:

- The maximum limit is set per IHCP Provider ID.
- The RAC may request no more than 300 medical records per individual audit per Provider ID and no more than 600 medical records per calendar year per Provider ID.
- The RAC may not make requests more frequently than every 90 days.
- The FSSA may authorize the RAC to exceed the limit. Affected providers are notified in writing.

Contact Information

For questions about the Medicaid RAC program, call 800-457-4515, Option 8. If you have received an audit letter and have questions specific to your audit, contact the person listed in the letter.

Member Utilization Review

Member utilization review identifies members who use IHCP services more extensively than their peers. Members may be selected for utilization review based on their claim history. Reviews can also be initiated due to reports of potential overuse or abuse from various sources, such as providers and other agencies.

Any form of overuse or misuse of services may identify a member for potential inclusion in the Right Choices Program (RCP). The RCP is designed to provide high-intensity member education, care coordination and utilization management to eligible Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise and Traditional Medicaid members identified as overusing or abusing services.

Common reasons for referral to the RCP include the member being treated by several physicians for the same or similar medical condition, purchasing the same or similar medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered emergencies. In addition, referrals are made when members are suspected of activities such as prescription forgery or selling drugs, supplies or equipment obtained through Medicaid, and also when members pay cash for Medicaid-covered services that would exceed predetermined standards as outlined in *42 CFR 456.709.*

RCP members are assigned to one primary medical provider (PMP) and one pharmacy. These providers coordinate the member's medical services in a manner that is in the best interest of the member. If the member requires services from a different provider, such as a specialist, the PMP must submit a referral to the member's RCP Administrator; otherwise, the services will not be reimbursed.

Providers can identify RCP members during the eligibility verification process, performed via the Portal, Interactive Voice Response (IVR) system or 270/271 electronic transaction. These mechanisms also identify the names of the IHCP lock-in providers to which the RCP member is assigned. See the *Right Choices Program* module for more information.