Program Integrity 101

Office of Medicaid Policy Planning

The Indiana Family and Social Services Administration
Indiana Health Coverage Programs
2023

Disclaimer

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

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Meet the Program Integrity Team

Interim PI Director

Lindsey Lux, Medicaid Deputy Director & Chief of Staff

Audit Team

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Nellie Hardin-Quarles, CPC, CPEDC - Auditor

Donesha Sangster - Auditor

Marion Maxwell, RHIT - Audit Compliance Coordinator

Allison Majors - Audit Assistant

Investigations Team

Ben Ford, CFE - Investigations Manager

Christina Overstake, CPC, CPMA - Auditor

Austen Hurt - MCE Coordinator

Peter Harrah - Investigator

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Agenda

Program Integrity 101

- About Program Integrity
- PI Organization Chart
- Federal and State PI Authority
- Auditing partners
- PERM RY24
- Post-Pay Audits and workflow
- Voluntary Self Disclosure
- Pre-Payment Review
- Targeted Probe and Educate
- Investigations
- Top 10 Medical Record Review Errors
- Tips to surviving an audit
- Contact Information

Program Integrity (PI)

Program Integrity (PI)

"Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering high-quality and necessary care, and preventing fraud, waste, and abuse."

- *Medicaid and CHIP Payment Access Commission (MACPAC), June 2019 Report to Congress*

NOTE: Federal share of all Medicaid recoveries must be repaid to CMS within 365 days of overpayment notification

PI Authority - Federal

42 CFR 455 Program Integrity: Medicaid

- Authorizes a state fraud detection and investigation program within each state to monitor the Medicaid program.
- Requires the state plan to include requirements for identification, investigation, and referral of fraud and abuse.
- Requires methods to ensure that services reimbursed by Medicaid were actually furnished and were furnished to beneficiaries.

42 CFR 438 Managed Care (section 438.608)

Implements these requirements onto MCEs

PI Authority – Federal, cont.

42 CFR 456 Utilization Control: Subpart A and B

- Authorizes state-wide utilization control unit that will monitor the Medicaid program to include a post-payment review process.
- Implementation of processes and procedures to ensure Medicaid dollars are being used properly and the program is working effectively.
- Creates the external process on what the agency will require from the provider as far as appropriateness and the quality of Medicaid services to be provided.

PI Authority - State

Indiana Code 12-15

IC 12-15-13 Provider Payment; General

IC 12-15-13.5 Clean Claim

IC 12-15-23 Improper Payments; CE to MFCU

Indiana Administrative Code 405 IAC 1 (Member and Provider Services)

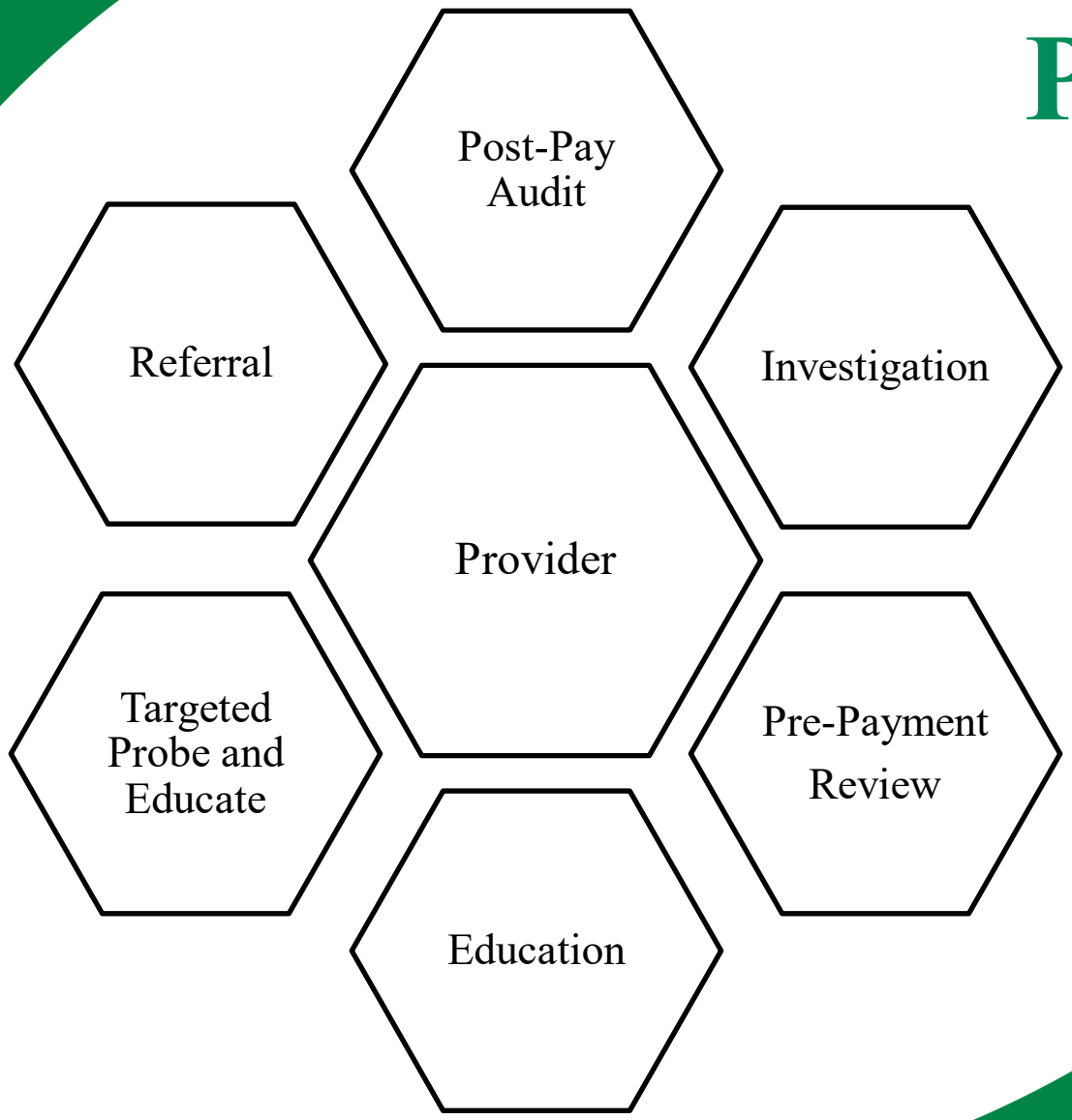
405 IAC 1-1.4 Program Integrity and Appeals

405 IAC 1-1-3 Claim Administrative Review and Appeals

405 IAC 1-1.4-7 Prepayment Review

405 IAC 1-1.4-9 Provider audits; overpayments; recovery

PI Tools


Post-Pay Audit
Referral
Investigation
Provider
Targeted Probe and Educate
Pre-Payment Review
Education

Other Auditing Entities

- Health and Human Services (HHS)
  - Centers for Medicare and Medicaid Services (CMS)
    - Unified Program Integrity Contractor (UPIC)
    - Payment Error Rate Measurement (PERM) Audit
  - HHS Office of Inspector General (OIG)
- Indiana Attorney General
  - Indiana Medicaid Fraud Control Unit (MFCU)

Post-Pay Audits

How are providers selected?

- Data Mining: focuses on a specific issue that is reflected in all our data
- Peer Provider Comparison: comparing providers amongst themselves
- Outside referrals received from Provider and Member concern line
- Referrals from other FSSA divisions

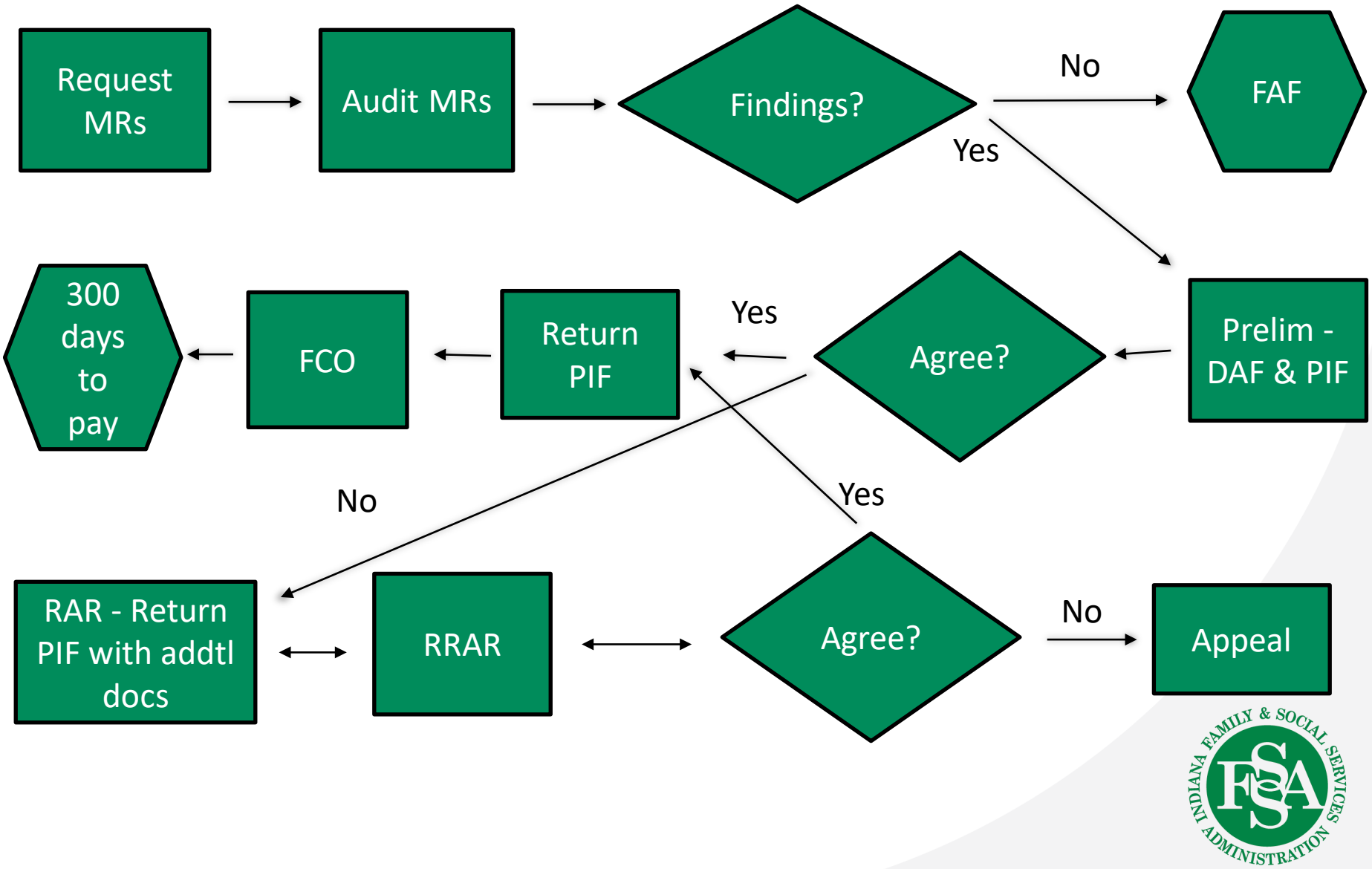
Types of Post-Pay Audits

- Self Audit/Desk Audit: provider is requested to review their records and provide information as to incorrect coding and/or billing
- Medical Record Review: records are requested from the provider and are reviewed for incorrect coding and/or billing or documentation issues
- On-Site Audit: announced or unannounced visits where documentation is reviewed and/or gathered at the provider's place of business

Audit Process

1. *Audit Notification* (AN) – Notice of audit with request of medical records
2. On-site or in-house medical record audit
3. *Draft Audit Findings* (DAF) letter of preliminary audit results
4. *Request for Administrative Reconsideration* (RAR) and *Response to Request for Administrative Reconsideration* (RARR)
5. *Final Calculation of Overpayment* (FCO) letter or *Final Audit Findings* (FAF) letter
6. Administrative appeal process
7. Recoupment of overpayment

Audit Process Workflow



Voluntary Self-Disclosure of Provider Overpayments

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

PI Authority – Federal, Self-Disclosure

42 U.S.C. § 1320a-7k(d)

Mandates the self report and return of overpayments within in 60 days

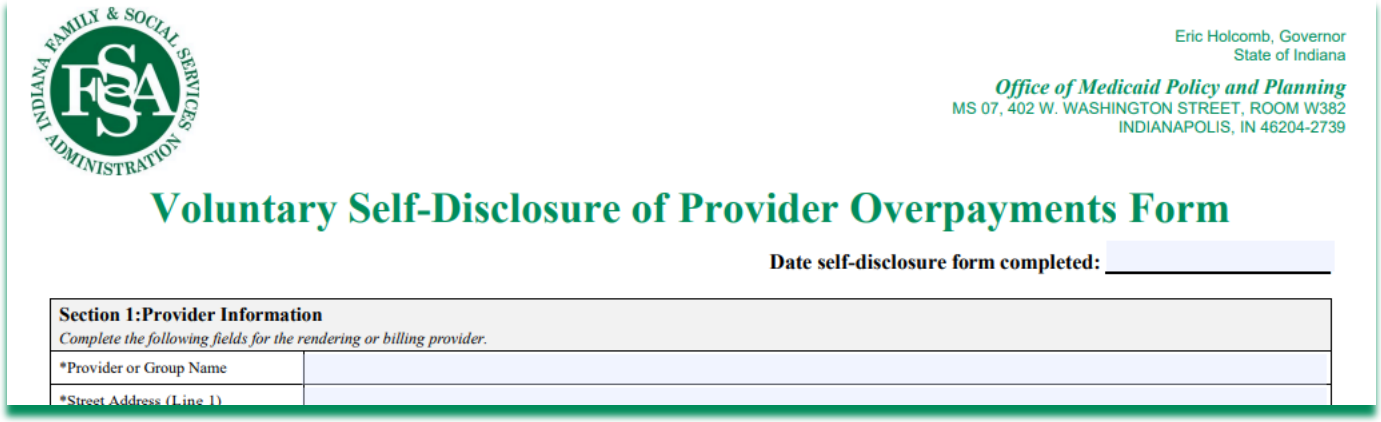
Section 6402(d) of the *Patient Protection and Affordable Care Act (PPACA) of 2010, Pub. L. 111-148*, title VI, Mar. 23, 2010, 124 Stat. 75

Voluntary Self-Disclosure

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.

IHCP Requests self-disclosure protocol be used in the following scenarios:

- Specific Compliance Issues
- Cumulative amounts greater than $1000
- Fraud or violations of law



Eric Holcomb, Governor
State of Indiana

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Voluntary Self-Disclosure of Provider Overpayments Form

Date self-disclosure form completed: _____

Section 1:Provider Information *Complete the following fields for the rendering or billing provider.*	
*Provider or Group Name	
*Street Address (Line 1)	

Voluntary Self-Disclosure, con't

Benefits of Voluntary Self-Disclosure

- Results in a better outcome for the provider
- Provider will be compliant with the law
- Interest will not be assessed on the disclosed overpayment

Potential consequences if IHCP discovers the matter independently

- Recoupment of improper reimbursements *with interest*
- On-site or in-house audit of medial records
- Placement on Prepayment Review
- Referral for administrative sanctions
- Referral to MFCU

Statistically-valid Random Sampling and Extrapolation

- If a provider chooses to utilize the providers should submit an explanation of the extrapolation process utilized and how the overpayments were discovered
- If a provider audits or reviews their Medicare claim population, providers **cannot** use Medicare error rate on their Indiana Medicaid claim population

Pre-Payment Review (PPR)

What is Pre-payment Review (PPR)?

- Educational tool which reviews claims before they're paid
- Contracted through the current FADS contractor
- Supporting documentation must be included with every claim
- Claim will suspend for review prior to payment
- Tailor for specific claim types, code types, provider types, places of services, etc.
- Providers must meet **85%** accuracy for three (**3**) consecutive months and maintain **10%** claim volume (prior to placement)

Targeted Probe and Educate (TPE)

Targeted Probe and Educate

- Educational tool for more 1 to 1 assistance
- Most providers and suppliers will never need TPE
- Only used for those who have high denial rates or unusual billing practices.
- Goal is to help providers quickly improve
- 3 rounds to improve before further action considered

Investigations

Investigations

The Role of Investigations

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

Investigations, con't

Example 1

A member calls the concern line to report that they suspect that their dentist billed Medicaid for an exam and a cleaning they did not render to them.

Outcome:

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

Example 3

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

Outcome:

The State performs a preliminary investigation on the provider and finds that a credible allegation of fraud exists. The State refers the case to the MFCU and requests that the provider be placed on payment suspension.

Example 2

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

Outcome:

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

TOP 10 Medical Record Findings
June 2022 – June 2023

Medical Records Audit Findings

June 2022-June 2023

1.Medical record documentation not provided to support the level of service billed - Incorrect use of E/M procedure codes (i.e.: upcoding indicator for professional claims: office/clinic, inpatient, nursing facilities)

2.Incorrect use of Modifier 59 - PT and OT services using 99211 with modifier 59 along with therapy procedure codes.

3.Incorrect use of Modifier HO, HN, HP used inappropriately for Physician Assistants and other midlevel providers (i.e.: not using HE modifier for behavioral health services)

Medical Records Audit Findings, con't 1

June 2022-June 2023

4. Incorrect use of E/M codes related to place of service care was rendered (i.e.: not using Nursing Facility E/M for Residential psychiatric treatment facilities)

5. Incorrect number of units billed based on MR documentation (i.e. - Home health services, ABA services)

6. Plan of Care is signed by the Provider after the claim paid date

Medical Records Audit Findings, con't 2

June 2022-June 2023

7. Treatment plans not being completed timely, no patient or patient representative signatures

8. Lack of provider credentials on signature lines

9. Lack of dates on provider signatures (required per 405 IAC 1-1.4-2 to verify medical records are documented prior to associated claim submission)

10. Lack of patient identification on each page of the medical records (patient name, Date of services, place of service, Date of birth and/or medical record number)

Surviving an Audit

- Don’t Panic
- Read the medical record documentation request or additional documentation request thoroughly
- Identify where to return the records to
- Identify the due date
- Identify the documents that are being requested
- Collect all of the requested documentation including all records necessary to support the services for the dates requested
- Make sure the medical records collected are complete and legible and are for all of the dates of service on the claims requested
- If you are copying the records, make sure they are legible, and that both sides of a double-sided document are included
- Verify all documentation requested is included in your submission
- Include the name and telephone number of the contact person for the request
- Return all requested documents to previously identified place
- Comply by the deadline
- It is the billing provider’s responsibility to obtain any necessary information required for the record review, regardless of the location of the documentation.

Questions?

Contact Information

Audit

1-800-457-4515

ProgramIntegrity.SUR@fssa.in.gov

Voluntary Self-Disclosure

1-800-457-4515

ProgramIntegrity.SUR@fssa.in.gov

PrePayment Review

1-800-457-4515

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Investigations

1-800-457-4515

ProgramIntegrity.fssa@fssa.in.gov

Thank you for attending!