Current Trends in Medicaid Audits

• Rationale for Increased Medicaid Audits

  – The Deficit Reduction Act of 2005 created a new federal Medicaid Integrity Program ("MIP")
    
    - The MIP is a comprehensive Federal strategy to:
      
      • Prevent and reduce provider fraud, waste, and abuse in the $300 billion per year Medicaid program, and
      
      • Recover improper payments made under the Medicaid program.
Current Trends in Medicaid Audits

- Under the MIP:
  - CMS has hired contractors to review Medicaid provider activities, identity overpayments, audit claims, and educate providers on program integrity issues.
  - CMS provides support and assistance to states in their efforts to combat Medicaid fraud and abuse.
Current Trends in Medicaid Audits

• Rationale for Increased Medicaid Audits
  – The Affordable Care Act (Health Care Reform bill)
    - Expansion of Medicaid program
    - Decrease in state funding for Medicaid
  – Medicaid Fraud Control Unit (Overseen by U.S. Department of Health and Human Services - Office of Inspector General)
    - Aim is to investigate and prosecute fraud by Medicaid providers
    - Units are administered by the States themselves but are funded on a matching basis by the Federal Government
Current Trends in Medicaid Audits

– Focus of President Obama’s Administration
  - Improper payment rate reductions are part of the Administration's efforts to eliminate errors and prevent waste and fraud in federal health care reimbursement programs

• Expansion of Providers Typically Subjected to Audits
  – Historically
    - Pharmacies, Durable Medical Equipment (“DME”) Providers, and AIDS clinics
Current Trends in Medicaid Audits

- Current Trend
  - Home health agencies, DME providers, and health care clinics
  - However, Medicaid has expanded its efforts to all other types of providers, for example:
    - Group Practices and Individual Physicians
    - Physical Therapists, Occupational Therapists and Speech Therapists
Current Trends in Medicaid Audits

• Expansion of Audits Beyond Medical Necessity Analysis

  – Historically - Basis for Audits has been:
    
    - General – Documentation insufficient to support "medical necessity"
    
    - Pharmacy – Insufficient inventory purchases

  – Current Trend
    
    - Scope of audits has expanded beyond "medical necessity" review to inaccurate or improper cost reporting, improper claim submission, unacceptable practices, fraud, abuse, and mistakes
Current Trends in Medicaid Audits

- Compliance with supervision requirements (e.g. physician assistants and therapy assistants)
  - Indirect vs. Direct supervision requirements
  - Board regulations vs. Medicaid reimbursement requirements
  - Civil liability vs. criminal liability
Medicaid Audits and Overpayment Appeals

- Basic Rules and Regulations Governing Medicaid Programs
  - Medicaid policy addresses the standards for furnishing and billing for services, including:
    - Documentation required to support billing and reimbursement
    - Request for authorization
    - Appropriate, necessary and reasonable services
    - Who may perform the services or provide the goods
    - Quality of services performed or goods provided, frequency, duration, reassessment, continuation, etc.
Medicaid Audits and Overpayment Appeals

- A provider may be terminated as a Medicaid provider for failing to repay a Medicaid overpayment. Similarly, professional licensing boards may discipline licensees (e.g. physicians) for failing to repay Medicaid overpayments.
Medicaid Audits and Overpayment Appeals

• Audit Selection Process
  – Random selection
  – Type of provider
  – Type of service
  – Data analysis reflects that provider is outside the norm among peers in ordering/provision of services
  – Complaints by patients, disgruntled employees, competitors and others
  – Complaints from licensing authorities
  – Leads from other regulatory or governmental agencies
  – Payment Error Rate Measurement ("PERM") (if applicable)
Medicaid Audits and Overpayment Appeals

- Overpayment Calculation
  - Dependent upon basis of audit:
    - Overall deficiency
      - Not claim specific (e.g. licensing deficiency or supervision deficiency)
      - Will result in blanket overpayment for all services rendered
Medicaid Audits and Overpayment Appeals

- Medical Records Review
  - Claim specific – based on specific service provided; or
  - Statistical Methodology - sample of selected claims taken from population of paid claims over specific period (e.g. 1 year)

- Purchase Acquisition Records Review
  - Comparison of properly documented product acquisitions to paid Medicaid claims
Medicaid Audits and Overpayment Appeals

- Statistical Extrapolation
  - May be used to determine the amount of the overpayment
  - Process:
    - Medicaid determines the amount of overpayment in a sample set of claims and then applies a statistical extrapolation formula to estimate the overpayment across the universe of claims the provider or supplier submitted over the selected audit period (usually 2 years)
Preparing for Audits

• Clinical Chart Reviews

  – Documentation must be contemporaneous with the services furnished or goods provided
    - Notes must be legible
  – Medicaid policy states what documentation is required to support the goods and services rendered or billed
    - Need proper documentation of "medical necessity" and "level of care"
Medicaid Audits and Overpayment Appeals

• Clinical Chart Reviews
  – Proper Documentation is critical. Overpayments are often based on improper payments associated with the following:
    - Unsupported Services – Records submitted by provider are not sufficient to justify diagnosis, admissions, treatments performed or continued care
    - Medical Unnecessary Services - Documentation in the medical records indicates that the services or products received were not medically necessary
Medicaid Audits and Overpayment Appeals

- Incorrect Coding – Documentation submitted does not support the reimbursement code submitted

- Non-Covered Costs or Services – Costs or services not reimbursable because they do not meet reimbursement policies
Preparing for Audits

• Medicaid Program Compliance Reviews - Standard
  – Reimbursement chart review
    - Compliance with provider agreement and manuals;
    - Compliance with reimbursement regulations
      • Form of orders
      • Proof of delivery
      • Proof of attendance
      • Supporting tests
    - Required pre-authorizations
Preparing for Audits

– Licensing compliance
– Inventory purchases
– Supervision requirement compliance
Preparing for Audits

- Medicaid Program Compliance Reviews
  - Pharmacy Audit Focal Points
    - Prescription review
    - Documentation review
      - Invoice review
      - Prescriber order authorizations
      - Dispensing and billing records
      - Sufficient inventory "legally" acquired
Preparing for Audits

• Medicaid Program Compliance Reviews
  – Pre-Audit Measures to Reduce Adverse Results
    - Maintain accurate documentation
    - Develop and comply with a Compliance Program
    - Perform periodic retrospective self-audits
    - Keep provider enrollment information current, including address, change of ownerships, and change of officers/directors/managing employees
Responding to Audits and Overpayment Determinations

• Medicaid Audit Process
  – Medicaid reviews allegations against provider
  – Either: Onsite inspection or Demand of records/documentation
    from provider
  – Review of records/documentation submitted
    - Policy issues
    - Medical necessity and level of care issues
  – Preliminary Investigation
  – Full Investigation
  – Administrative Hearing (if requested by provider)
Responding to Audits and Overpayment Determinations

- Medicaid Audit Process
  - On-site inspection – Providers should:
    - Always retain originals
    - Document what has been provided
  - Demand for Records/Documentation - Providers should:
    - Document what has been provided and when provided
    - Most common error is not producing all relevant documents
Responding to Audits and Overpayment Determinations

• Initial Audits and Preliminary Findings
  – Preliminary Investigation
    - Preliminary determination of overpayment or violation
    - Determination based upon:
      • Medicaid descriptions, policies, limitations and exclusions found in provider handbooks, billing bulletins and Provider Agreement
    - Provider Response Options
      • Submit additional documentation (if possible)
      • If an overpayment, make payment in full or establish payment plan

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Responding to Audits and Overpayment Determinations

• Preliminary Findings
  – Lack of documentation to support medical necessity
  – Licensing deficiencies
  – Failure to satisfy provider participation requirements
  – Lack of pre-authorizations
  – Any technical non-compliance with provider contracts and payor manuals
  – Any technical non-compliance with physician orders or prescription requirements
Responding to Audits and Overpayment Determinations

- Alleged kickback arrangements
- Upcoding review
- Overutilization – excessive and unnecessary tests
- Inventory shortage for equipment, supplies and medications
- No proof of delivery
- Failure to comply with Physician Assistant and Medical Assistant supervision requirements
Responding to Audits and Overpayment Determinations

- Preliminary Findings Suggesting Health Care Fraud
  - Billing for services not rendered:
    - Medical services or procedures that were not actually performed
    - Goods and/or services that were not provided
  - Billing for non-existent or unnecessary services
  - Billing for more expensive products/services than were actually provided
Responding to Audits and Overpayment Determinations

- Paying kickbacks:
  - To recipients for use of Medicaid numbers
  - To providers for patient referrals
- Duplicate or double billing
Responding to Audits and Overpayment Determinations

- Preliminary Findings Suggesting Health Care Fraud in Pharmacies
  - Forgery – bogus prescriptions and invoices
  - No prescription
  - Altering prescriptions
  - Shorting quantity dispensed with full billings
  - IOUs – partial fills for full billings
  - Billing one drug and dispensing another one
Responding to Audits and Overpayment Determinations

- Dispensing samples or expired drugs
- Returns to stock not credited
- Authorized refills billed but not dispensed
- Dispensing drugs purchased from unlicensed drug wholesalers
- Drug diversion schemes
Responding to Audits and Overpayment Determinations

• Final Determinations
  – A full investigation must continue until:
    - Appropriate legal action is initiated
    - The case is closed or dropped because of insufficient evidence to support the allegations; or
Responding to Audits and Overpayment Determinations

- The matter is resolved between Medicaid and the provider. This resolution may include but is not limited to:
  
  • Sending provider a warning letter, giving notice that continuation of the activity in question will result in further action
  
  • Suspending or terminating provider from participation in the Medicaid program
  
  • Seeking recovery of payments; or
  
  • Imposing other sanctions
Responding to Audits and Overpayment Determinations

- **Provider Rights/ Options**
  - **Appeal** - Failure to timely appeal results in forfeiture of appeal rights
  - **Pay Overpayment**
    - Failure to do so may result in:
      - Withholding of Medicaid and Medicare payments
      - Termination of Medicaid provider number
      - Additional sanctions being imposed
  - **Payment Options**
    - Full payment or payment plan

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Responding to Audits and Overpayment Determinations

- Commonly Utilized Defenses and Strategies
  - Substantive Defenses
    - Medical necessity
    - Expert opinion on alleged off-brand use or experimental therapy
  - "Treating Physician Rule" - Treating physician is in the best position to make determinations of "medical necessity" and his/her determination should prevail over analysis based solely on paper review
  - Waiver of liability defense
Responding to Audits and Overpayment Determinations

- Provider without fault defense
- Challenge denials on the basis of lack of Medicaid policies, lack of notice to providers or failure to follow Medicaid's own policies
- Overpayment and/or audit timeframe is outside the timeframe allowed by law
Responding to Audits and Overpayment Determinations

- **Contesting Statistically Based Overpayments**
  - Sample selected was not random
  - Sample size was too small
  - Review of claims in sample was inaccurate so extrapolated overpayment was also inaccurate
  - Statistical method/formula used was inaccurate or invalid
  - Sample is not representative of the universe
    - Simple random sampling vs. stratified sampling
  - Sample was biased
Preparing for, and Responding to, Medicaid Audits

- Conclusion
  - Increase in audits cannot be ignored
  - Consequences are significant
  - Pre-audit measures greatly reduce adverse findings
  - Timely post-audit response is critical