

HEALTH LAW

Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Medicaid Integrity Contractors: The Next Big Audit Wave

December 11, 2009

Medicaid claims are becoming an increasing target of government scrutiny due in large part to implementation of the Medicaid Integrity Program (the "MIP"). The MIP is a Medicaid anti-fraud initiative introduced by Congress in the Deficit Reduction Act of 2005. To implement the MIP, Congress has granted funding to the Centers for Medicare & Medicaid Services ("CMS"), including \$5 million in fiscal year 2006, \$50 million in each of fiscal years 2007 and 2008, and \$75 million for fiscal years 2009 and beyond.¹ This level of financial funding demonstrates the federal government's commitment to fight Medicaid fraud and abuse (while continuing to focus on Medicare fraud and abuse).

With this increasing focus on Medicaid claims, providers now need to prepare for audits of Medicaid claims in addition to their work on Medicare audit initiatives, such as Recovery Audit Contractors ("RACs") and Zone Integrity Contractors ("ZPICs"). This Health Law Alert will assist in that preparation by providing an overview of the MIP program and the audits that will occur under the program and by offering practical suggestions to assist providers in preparing for these new audits.

MIP Background

The MIP program is the federal government's first attempt to audit state-run Medicaid programs directly. Historically, Medicaid claims have received little government scrutiny, often resulting in a high error rate for these claims. According to a former state Medicaid Inspector General, the Medicaid program has an 18.5 percent error rate and loses more money than any other federal program.²

Through the MIP, the federal government is now directly combating fraud and abuse in state-run Medicaid programs. As part of the MIP initiative, Congress has instructed CMS to publish a Comprehensive Medicaid Integrity Plan and to support states' efforts to combat fraud and abuse in their respective Medicaid programs. In addition, the MIP requires CMS to contract with

¹ See 42 U.S.C. § 1396u-6(e).

² See "Medicaid Integrity Contractor Audits Soon to Follow RACs," *Healthcare Auditing Strategies*, published by HCPro, Inc. (Sept. 2008).

Medicaid Integrity Contractors ("MICs") to provide anti-fraud education to Medicaid providers and to identify overpayments by conducting post-payment audits of Medicaid claims.³

CMS has delegated responsibility for the MIP to the Medicaid Integrity Group (the "MIG"). The MIG is overseen by the Office of the Group Director and consists of three divisions. The first division, the Division of Medicaid Integrity Contracting, oversees procurement of MIC contracts and generally oversees the MICs. The Division of Fraud Research and Detection is responsible for identifying fraud patterns and trends and reporting that information to the MICs and to the states. Finally, the Division of Field Operations, which consists of approximately 40 field staff in New York City, Chicago, Atlanta, Dallas, and San Francisco, conducts program integrity reviews of the states and otherwise provides technical assistance and training to the states.⁴

The MIG oversees three types of MICs—Education MICs, Review MICs, and Audit MICs, each with a different role. Education MICs are responsible for educating providers, beneficiaries, and others on program integrity and quality of care issues. Review MICs analyze Medicaid providers' claims data for evidence of atypical billing practices that could result in overpayments. Audit MICs conduct post-payment audits of Medicaid providers.⁵ The Audit MICs determine which providers to audit in part based on leads received from CMS, state agencies, or the Review MICs.⁶

CMS has divided the country into five MIC jurisdictions, each of which encompasses two CMS regions. Contracts for Education MICs, Review MICs, and Audit MICs are awarded separately for each of the five MIC jurisdictions, and CMS has awarded contracts and assigned task orders to the various MIC contractors on a staggered basis, beginning in April 2008.⁷

The Audit MICs have commenced audits of Medicaid providers in most jurisdictions, and audits are anticipated to begin in the remaining jurisdictions by June 2010.⁸ This past summer, CMS indicated that Audit MICs were performing nearly 500 audits of a variety of providers, including hospitals, long term care facilities, physician practices, transportation services, and laboratories.⁹

*The MIC Audit Process*¹⁰

All Medicaid providers are subject to MIC audits. Although Audit MICs, unlike RACs, are not paid on a contingency fee basis, Audit MICs are eligible for financial bonuses based on the effectiveness of their audits.

³ Deficit Reduction Act of 2005, Pub.L. 109-171, § 6034.

⁴ See CMS publication, "Medicaid Integrity Program A to Z," available at <http://www.tha.org/HealthCareProviders/Advocacy/FederalIssues/MedicaidRACAudits/index.asp>.

⁵ See 42 U.S.C. § 1936(b).

⁶ See *id.*

⁷ See the CMS Medicaid Integrity Group's "Review and Audit Medicaid Integrity Contractor Procurement Status" chart; see also CMS' "Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program: FYs 2009-2013" (published in July 2009).

⁸ See the CMS Medicaid Integrity Group's "Review and Audit Medicaid Integrity Contractor Procurement Status" chart.

⁹ See transcript of the July 15, 2009 "CMS Special Open Door Forum: Medicaid Integrity Provider Audit Program."

¹⁰ Information in this section has been obtained from the CMS publication entitled "Medicaid Integrity Program A to Z." For additional information about the MIP, please see: <http://www.cms.hhs.gov/MedicaidIntegrityProgram/>.

Review MICs perform post-payment reviews of Medicaid claims and then recommend selected providers to be audited by the Audit MICs. CMS is responsible for ensuring that investigations or other audits of these providers for similar Medicaid issues are not already underway by state Medicaid agencies, state or federal law enforcement, or Medicare contractors.

If a provider is selected for an audit, an Audit MIC should notify a provider via letter of the specific claims and records to be audited prior to commencing an audit. Audit MICs can review Medicaid claims as far back as permitted under the laws of the respective states that have paid the claims. The Audit MICs also are not limited to a set number of claims for which they may request records and may request that records be produced in as little as two weeks.

An Audit MIC may request that a provider produce the relevant records in specific formats, such as color or electronic copies, although Audit MICs do not have to reimburse providers for the cost of producing the records. If a provider has concerns about the records request, the audit, or the production timeline, the provider should contact the Audit MIC. Requests for time extensions are generally granted, so long as the extensions do not compromise the integrity or timeliness of the audit.

The Audit MIC also will contact the provider to schedule an entrance conference (in-person or via telephone) to describe the audit's scope and objectives. For most audits, the provider will send the requested records to the Audit MIC for a "desk audit" at the Audit MIC's office. However, in some circumstances Audit MICs may conduct on-site audits at the provider's office. This type of audit is known as a "field audit."

After completing the audit, the Audit MIC will present preliminary findings to the provider at an exit conference, and the provider should have an opportunity to comment and to provide additional information. If the Audit MIC concludes that there is a potential overpayment to the provider, the Audit MIC will share a draft report with CMS for approval and with the state for review. The provider should also receive a copy of the report for review and comment.

Based on information provided by the state or by the provider, the findings and any assessed overpayment may be adjusted before the audit report is finalized. However, CMS has the ultimate responsibility for determining the final overpayment in any audit. CMS will send the final audit report to the state, and the state will then have 60 calendar days to repay the federal share of the Medicaid overpayment to CMS, regardless of whether the state recovers, or seeks to recover, the overpayment from the provider. The state is responsible for issuing the final audit report to the provider in accordance with the state's respective administrative process for overpayment recovery.

In the event that the provider disputes the overpayment assessed in the final audit report, the provider may exercise applicable appeal or adjudication rights. Unlike other CMS audit contractors, such as RACs and ZPICs, which must follow specific appeal processes set forth in federal regulations, providers' appeal rights under the MIP are determined by the laws of the respective states.

Tips to Prepare for an Audit

To be prepared for an Audit MIC, we recommend that providers consider the following:

- Develop policies and procedures in advance for timely responding to audit requests. These policies and procedures should include the tracking of requests and responses and designation of an internal point of contact to direct the audit.
- Verify that the appropriate individual is designated as the contact person with the state. A letter from the Audit MIC will be sent to the individual listed with the state as the provider's contact person. Thus, providers should contact the state to verify that the appropriate contact person is listed.
- Ensure that correspondence from an Audit MIC is directed to the appropriate internal point of contact. An Audit MIC letter may be addressed on the private contractor's letterhead rather than CMS, Medicaid, or state letterhead. Providers should train personnel on how to identify Audit MIC letters and to direct such letters to the internal point of contact as soon as they are received.
- Alert legal counsel when notice of an audit is received. Because MICs are looking for fraud and abuse, providers should consult with legal counsel to ensure that their rights are being protected. Legal counsel can then assist the provider in monitoring and documenting the audit process, protecting the provider's rights, and ensuring that Audit MICs follow CMS and state guidelines.
- Provide complete records in a timely manner. Providers should keep track of all deadlines and ensure that records are timely submitted. Before submitting any records, providers should verify that all necessary records to support the audited claims are being provided. Providers also should maintain a copy of all documents provided to the Audit MIC.
- Learn the appeal procedures for appealing unfavorable audit results. Providers should develop policies and procedures for appealing adverse Medicaid audit results that take into account the applicable state requirements. Because each state's appeals process will vary, providers operating in multiple states especially should become familiar with each state's appeal process to ensure that appeals are timely and appropriately made.

Conclusion

By understanding the MIP audit process, providers can prepare for the arrival of Audit MICs to reduce the potential disruption from an MIC audit. Providers should prepare in advance by maintaining strong compliance programs, which should include appropriate education and training on Medicaid billing practices as well as the performance of internal audits to ensure that Medicaid claims are being billed appropriately. If providers determine through these internal audits that mistakes were made in billing Medicaid claims, the providers should correct these

mistakes and return any overpayments. Additionally, providers also should develop policies and procedures for responding to audits and appealing any audit results. Through effective internal reviews and audits, providers can ensure that they are appropriately billing Medicaid claims and minimize the likelihood of being subject to MIP audits. If you have any questions, please contact one of the attorneys in our Healthcare Practice Group listed below.

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