**Introduction**

- We are entering a time of unprecedented claims scrutiny and audit activity as Audit MICs and RACs begin auditing.
- Hospice entities must adopt a renewed focus on compliance.

**MIC Overview**

- The Deficit Reduction Act of 2005 added Section 1936 to the Social Security Act
  - Created the Medicaid Integrity Program (MIP)
  - Required CMS to procure contractors (Medicaid Integrity Contractors or MICs) to perform certain functions:
    - Review provider actions (Review MICs)
    - Audit claims (Audit MICs)
    - Identify overpayments (Audit MICs)
    - Educate providers with respect to program integrity and quality of care (Education MICs)
- The focus of this presentation is Audit MICs
- In Nebraska, the Audit MIC is Health Integrity, LLC

**Steps in the Provider Audit Process**

*Step 1 – Data Analysis*

- The Medicaid Integrity Group (MIG) and Review MICs examine all paid claims using the Medicaid Statistical Information System (MSIS).
  - MIG identifies potential areas that are at high risk for overpayments or fraudulent claims that require additional review by Review MICs.
  - The Review MICs identify the specific providers on which the Audit MICs should focus their auditing efforts.
- Data driven approach intended to focus audits on those providers with "truly aberrant" billing practices.
Steps in the Provider Audit Process

**Step 2 – Vetting Potential Audits**

- Prior to providing an Audit MIC with an audit assignment, CMS "vets" the providers identified for audit with:
  - State Medicaid agencies
  - State and Federal law enforcement agencies
  - Medicare contractors
- Entities listed above are provided a list of the potential audits generated by data analysis. If any stakeholder is performing an audit of the same provider for similar Medicaid issues, CMS may cancel or postpone the Audit MIC’s audit of the provider.

**Step 3 – Audit MIC receives audit assignment**

- Upon completion of the vetting process, CMS forwards the audit assignments to the Audit MIC, and the Audit MIC immediately begins auditing.

**Step 4 – Audit MIC schedules entrance conference**

- Audit MIC’s initial communication with the provider includes the following:
  - An audit notification letter, which identifies a contact person in the Audit MIC and in most cases gives the provider two weeks' notice of the audit
  - Records request
- Audit MIC may coordinate with the provider to schedule an entrance conference to communicate relevant information regarding the audit, including its scope and objectives.
  - May be conducted in person or by phone

**Step 5 – Audit MIC performs audit**

- Most audits are desk audits
- As a general rule, the provider will have 30 business days to produce records.
  - The Audit MIC can authorize a 15 business day extension if requested and appropriately justified by the provider.

**Step 6 – Exit Conference and draft audit report**

- Audit MIC will coordinate with the provider to schedule an exit conference to communicate preliminary audit findings and tentative conclusions.
  - May be conducted in person or by phone
  - The provider will have an opportunity to comment on the preliminary findings and provide additional information where appropriate
- If the Audit MIC concludes that there is a potential overpayment, the Audit MIC also prepares a draft report.

**Step 7 – Review of draft audit report**

- Draft audit report submitted to several agencies for review, comment and approval:
  - Report shared with CMS for approval
  - Report submitted to the State for review and comment
  - Report provided to the provider for review and comment
- Where appropriate, the draft is revised and then shared again with the State
Steps in the Provider Audit Process

**Step 8 – Draft audit report is finalized**
- Upon completion of the review of the draft audit report, audit findings may be adjusted based upon the information provided by the State and the provider.
  - Guidance from CMS states that, “The provider will be given credit for payments it is able to justify.”
- At this point, the audit report is finalized.

**Step 9 – CMS issues final audit report**
- CMS sends its final audit report to the State.
- Per 42 C.F.R. §§ 433.316 (a) & (e), sending the final audit report to the State serves as CMS’ official notice to the State of the discovery and identification of an overpayment.
  - Under Federal law, the State must repay the Federal share of the overpayment to CMS within 60 calendar days, whether or not the State recovers, or seeks to recover, the overpayment from the provider.

**Step 10 – State issues final audit report to provider and begins overpayment recovery**
- The State will issue the final audit report to the Provider.
- The provider may exercise its appeal rights under State law at this time.

**RAC Overview**
- RACs are companies contracted by Medicare, tasked to identify and correct Medicare improper payments.
- RACs are compensated on a contingency fee basis based on the principal amount collected from and/or returned to the provider or supplier.
  - Although the RACs are responsible for correcting all types of improper payments (both overpayments and underpayments), during the demonstration program:
    - RACs identified and collected $992.7 million in overpayments (96%)
    - RACs ordered repayment of only $37.8 million in underpayments (4%)

**RAC Overview**
- **Objective** – To determine whether using RACs would be a cost effective way to identify and correct improper Medicare payments
- **Results** – The Demonstration Program proved highly “cost effective” for CMS
  - RACs identified and collected more than $1.03 billion in improper payments
  - CMS estimates that the RAC demonstration program cost approximately 20 cents for each dollar returned to the Medicare Trust Funds
RAC Overview
Making RACs Permanent

- Section 302 of the Tax Relief and Health Care Act of 2006
  - Made the RAC program permanent and required nationwide expansion by 2010
  - RAC program now operational nationwide

RAC Overview
The Future

- Section 6411 of the Affordable Care Act expands the RAC program to include:
  - Medicare Advantage (Part C);
  - Medicare Prescription Drug (Part D); and
    - CMS has delayed implementation of Medicaid RAC program
    - NE has submitted, and CMS has approved, its State plan

RAC Overview
RAC Vendors

- Region A – Northeast States
  - Diversified Collection Services, Inc., of Livermore, CA
    - [www.dcsrac.com](http://www.dcsrac.com)
- Region B – Midwestern States
  - CGI Technologies and Solutions, Inc. of Fairfax, VA
    - [http://racb.cgi.com](http://racb.cgi.com)
- Region C – Southeast States
  - Connolly Consulting Associates, Inc. of Wilton, CT
    - [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC)
- Region D – Western States (including Nebraska)
  - HealthDataInsights, Inc. of Las Vegas, NV
    - [http://racinfo.healthdatainsights.com](http://racinfo.healthdatainsights.com)

RAC Overview
Identifying Improper Payments

- RACs are permitted to attempt to identify improper payments resulting from:
  - Incorrect payments;
  - Non-covered services (including services that are not reasonable and necessary);
  - Incorrectly Coded Services (including DRG miscoding); and
  - Duplicate services

RAC Audits
Identifying Improper Payments

- Targeted Review – RAC audits are not random
  - RACs use proprietary data techniques to determine claims likely to be overpayments
- 2 types of reviews for improper payment
  - (1) Automated Review
    - A review of claims data without a review of records
  - (2) Complex Review
    - A review of records

RAC Audits
Complex Review Process

- In a complex review, the RAC will request records for review
  - RAC reviewers have a 3-year maximum look-back period
  - Record request limits published on CMS RAC website: [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)
- Importance of timely response to claims
RAC Audits
Complex Review Process
• RNs or therapists must make determinations regarding medical necessity, and certified coders must make coding determinations.
• RACs must comply with NCDs, interpretive manuals, LCDs, national and local coverage and coding articles.
  – Cahaba GBA, LLC – LCD on Hospice – Determining Terminal Prognosis
  – RACs may also develop internal guidelines to use in reviewing claims.
• Generally speaking, a RAC must complete complex reviews within 60 days from receipt of the requested medical records.
• Following its review, the RAC will issue a review results letter; adjust the claim on an RA; issue a demand letter to the provider setting forth the findings for each claim and notifying the provider of appeal rights.

RAC Audits
Contingency Fees
• RAC contingency fees range from 9 to 12.5 percent
• RACs are not entitled to keep their contingency fees if a denial is overturned on appeal
• RACs are authorized to use statistical extrapolation
  – RACs will be compensated based upon the extrapolated overpayment finding.

RAC/Medicare Appeals
  – Rebuttal
  – Discussion Period
  – Stage 1 – Redetermination
  – Stage 2 – Reconsideration
  – Stage 3 – Administrative Law Judge (“ALJ”) Hearing
  – Stage 4 – Medicare Appeals Council (“MAC”) Review
  – Stage 5 – Federal District Court

RAC Audits
Preparing for an Audit
• Providers cannot prevent audits, but they can prepare for increased claims scrutiny:
  – For RACs, identify a RAC point person, responsible for communicating with the RACs (register on RAC website)
  – For Audit MICs and RACs, identify an point person responsible for:
    • Internally monitoring protocols to better identify and monitor areas that may be subject to review
    • Responding to record requests within the required timeframes
    • Implementing an effective compliance program in and/or strengthening procedures currently in place

Key Compliance Issues
• Identify and monitor areas that may be subject to review
  – For RACs, approved audit issues
    • Note: RACs may request records outside of the approved audit issues.
  – For RACs and Audit MICs, OIG Work Plan and other OIG and CMS guidance documents
• Develop and implement effective processes to respond to record requests and prepare for appeals, if necessary.

Appeals Strategies
• Advocating the merits
  – Draft a position paper outlining factual and applicable legal arguments
  – Engage in the services of a qualified physician expert
  – Using medical summaries, illustrations, and other types of color-coded charts or graphs depicting the claims at issue that are user-friendly for the decision maker
• Audit defenses
  – Treating Physician Rule
  – Waiver of Liability
  – Provider without Fault
  – Reopening Regulations
  – Challenges to Statistics
**APPROVED AUDIT ISSUES**

**as of 03/25/2011**

**Region D (Nebraska)**

<table>
<thead>
<tr>
<th>Region-Medical Services</th>
<th>Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.</th>
<th>CMS Pub. 100-04, Chapter 11, §10, 40.2 and CMS Pub. 100-02, Chapter 9, §10</th>
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<td>104. while in Hospice</td>
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**OIG Guidance**

- **2011 OIG Work Plan**
  - Hospice utilization in nursing facilities

**Other Compliance Tips / Case Examples**

- Establish protocols for reviewing certain categories of cases
  - Eligibility reviews for beneficiaries with longer lengths of stay
  - Higher scrutiny of beneficiaries with certain diagnoses (i.e., Alzheimer’s disease, Failure to Thrive, CHF, COPD, etc.)
  - Focus on SNFs
- Review documentation for potential deficiencies and provide education
  - Review applicable LCD
  - Issues with EHR

**QUESTIONS?**

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