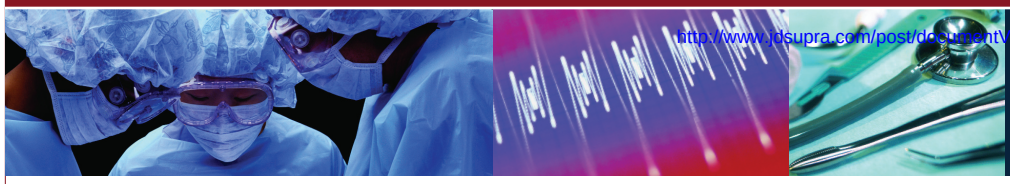

Duane Morris®
Attorneys at Law

MEDICAID INTEGRITY PROGRAM: *Piled Higher and Deeper*

By Joanne B. Erde, PA

Just when it appeared it could not get any worse than the Recovery Audit Contractor ("RAC") program, the rollout of the Medicaid Integrity Program ("MIP") began across the United States. The MIP is the first federal program to review and audit payments made by state Medicaid programs. Since this review function has historically been the exclusive purview of the states, the MIP is designed to provide an additional level of review beyond the established state Medicaid integrity program efforts. The main thrust of the MIP is to identify and recoup overpayments, although fraud referrals can also be made.

Similar to the RAC program, the MIP has subcontracted out audit function of the program to Medicaid Integrity Contractors ("MICs"). There are two types of MICs—review MICs and audit MICs. The review MICs are responsible for the 30,000-foot view, while the audit MICs perform the post-payment review of individual claims.

The review MICs analyze Medicaid claims data to identify high-risk areas and the potential vulnerabilities of each state's Medicaid program. The review MICs look for outliers using computer algorithms to identify claims profiles that are outside the norm, analyzing for perceived aberrancies, in a process known as "data mining." Some of the simplest errors that they are looking for are services rendered to dead people, duplicate claims, unbundling and outpatient claims rendered during an inpatient stay. The audit MICs will use the information gathered by the review MICs to scope their audits.

The audit MICs perform post-payment audits of selected Medicaid providers. They are tasked with reviewing paid claims (and also, in the future, cost-report and managed-care claims) to ensure that Medicaid services were properly documented, billed and paid in accordance with a specific state's Medicaid program. The audit MICs will conduct their reviews in a manner similar to the RAC, although MICs are not paid on a contingency basis. The MICs will generally request a sample of 100 inpatient and outpatient medical records for their review; occasionally, they will conduct field audits.

At the conclusion of an MIC audit process, MICs will provide a draft report of their results to the state Medicaid program for review. Once the state reviews and comments, the revised draft report is submitted to the provider for review and comment. If either the state or the provider disagrees with the report, an opportunity for negotiation exists; however, it is unclear how a disagreement between an audit MIC and a state (and/or a provider) will be resolved. Once this review process is completed, the audit MIC will issue a final audit report. The MIP will then collect the federal share of the overpayment from the state, and the state Medicaid program will collect the entire overpayment from the individual provider. An MIP audit is anticipated to take about one year to complete.

Both review and audit MICs have been chosen for some regions, and it is anticipated that more contracts will be issued soon. To date, audit and review MIC contracts have been awarded for the Mid-Atlantic states (Region III), the Southeast states (Region IV), the Southwest states (Region V), California and the Pacific Northwest states (Region IX and X) and the Central Rockies states (Region VIII). Currently, there are approximately 400 audits in process. As the MICs begin their audits, providers should be aware of several significant issues.

In the early audits, it was a challenge to identify the records that the MICs wanted to review. The initial MIP requests for medical records identified a patient only by his or her Medicaid number. Most providers cannot locate a medical record without a patient's name or Social Security number. After some negotiation, the MIP agreed to provide more identifying data. Overlapping investigations are another concern. The MIP may not investigate issues that have been or currently are being investigated by other agencies. If the MIC identifies claims or issues that relate to ongoing or prior investigations, the provider may want to notify the MIC immediately and request the cessation of the MIC audit of that issue.

The sampling and extrapolation methods employed by the audit MICs should also be carefully scrutinized. Unlike the RACs, the MICs will not review every claim; instead, they will select a sample and then extrapolate the results over the universe of claims. The MICs are limited by state law—they are allowed to engage in sampling only if state law permits it. Although most states permit sampling, state laws vary regarding permitted sampling and extrapolation methodologies. One issue to explore is sample size. State laws differ widely on what is considered an adequate sample amount. Florida case law provides that a 10-percent sample is required, whereas Ohio case law suggests that a sample as small as 0.5 percent does not violate due process. As the MIC audits progress, there is likely to be more debate about the adequacy of both the sampling and extrapolation methodologies.

Another area that merits close observation is the appeal process, which is also governed by state law. Providers are accustomed to a 120-day window to appeal Medicare coverage determinations. The state appeal process generally provides for much shorter appeal periods. In Florida, there is a 21-day appeal period; in New York, a 60-day appeal period; and in Illinois, a 10-day appeal period. Providers may want to educate themselves on their appeal rights when confronted with an MIC audit and overpayment determination. Otherwise, they will lose their right to contest the audit MICs' overpayment determination.

Although the MIP is just beginning the rollout of its audit function, providers should be prepared. MIP audits may potentially result in significant and material overpayment determinations. Providers should have an understanding of the audit and appeal processes, and pay close attention once an MIP audit commences. The experiences of providers in the RAC demonstration program underscore the fact that providers should be ready to protect themselves—or risk huge paybacks.

***Joanne B. Erde, PA**, a Duane Morris Health Law partner in Miami, assists providers on a variety of Medicare and Medicaid issues,including reimbursement and billing, corporate compliance, and healthcare fraud and abuse. If you have a question on this material or would like to discuss legal services, please contact her at jerde@duanemorris.com.*

Originally published as a special supplement to Modern Healthcare Magazine, June 2009.