AUDITS AND PROVIDER RESPONSIBILITIES

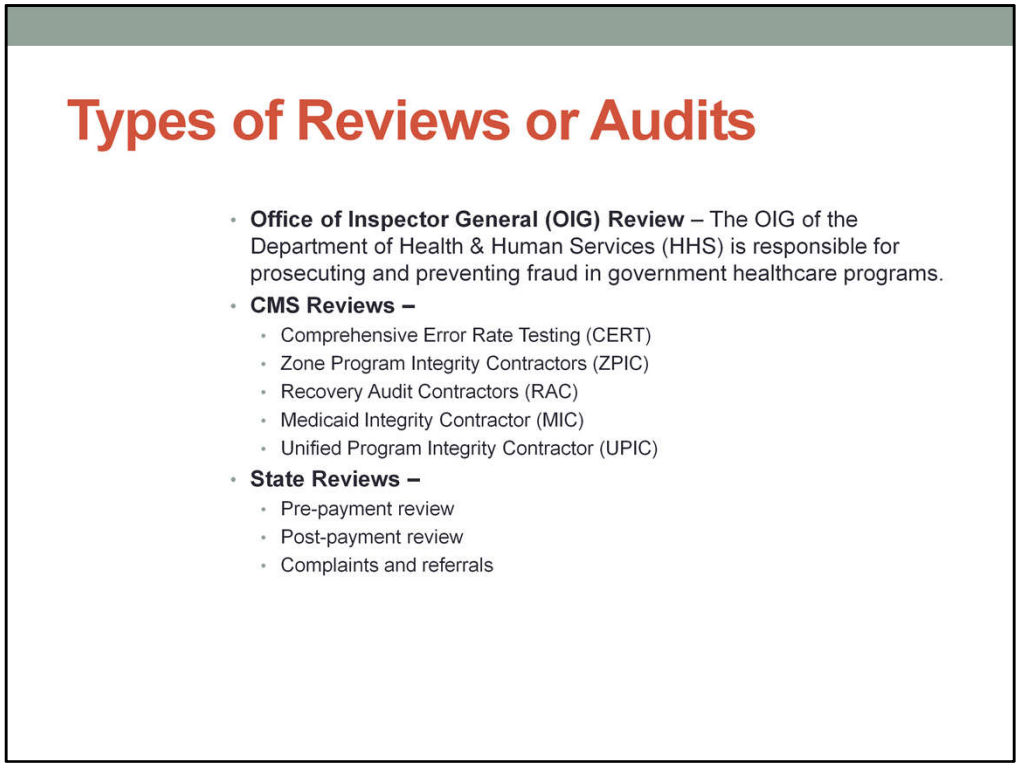
September 1, 2018

WYO MEDICAID
DIVISION OF HEALTHCARE FINANCING

PROVIDER AND BENEFITS MANAGEMENT UNIT
WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Objectives

- To promote an understanding of types of reviews or audits (federal and state)
- To promote an understanding of guidelines for audits
- Identify provider responsibilities
- Share Best Practices



OIG – They have their own inspectors and auditors and they can enter your office and inspect your files as far back as the first day of your practice, without a warrant.

2007 – OIG Medicaid Rehabilitative Services Audit in Indiana
"Review of Medicaid Community Mental Health Center Provider Services in Indiana," (A-05-05-00057) Indiana elected to include optional Medicaid coverage for medical or remedial "rehabilitative services" that are provided by community mental health centers (CMHC) in an individual or group setting.
The Indiana audit was notable for documentation that was incomplete, missing, or did not support services appropriately. The auditors did not review the content of the services provided, the medical necessity of the services provided, or the clinical strategies that were being implemented. This is a good example of an "is it there" audit where the payer was looking for technical compliance with regulations and not reviewing the clinical compliance or the quality of care.

2005 – OIG Audit of Adult Rehabilitation Services Program in Iowa The objective of this audit was to determine whether the State's claims for adult rehabilitation services met Federal and State Medicaid reimbursement requirements The OIG recommendations were that the State:
• Refund $6,244,154 to the Federal Government and
• Strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the beneficiary's rehabilitative needs and meet other Federal and State requirements." These audits all have good examples of services that did not meet federal requirements and many of the problem claims had more than one problem – not a covered service and also poorly documented for example. They also brought attention to the fact that many providers and apparently states as well were confused about what actually constituted a rehabilitative service. In Iowa many adult rehab services were thought by the federal government to be habilitative – not re-habilitative. **In other words they were services that were teaching hygiene and shopping (examples used in the audit) to people who had never gained these skills before and were learning them for the first time. In rehabilitative services, the OIG said, the skills being taught were those individuals had before they became mentally ill and then lost because of their mental illness. Rehabilitation services helped them re-gain these skills. For many providers this was new information.**

CMS Reviews – These vendors are either contracted by CMS or programs required by CMS to contract with a vendor. CMS, the State and vendors work together to prevent fraud and abuse. These vendors provide different types of activities. They can work to detect and correct past, improper payments, complete prepayment reviews, investigate instances of fraud , waste and abuse and measure improper payments.

The Division of Healthcare Financing's Program Integrity Unit completes pre-payment reviews, post-payment reviews, and complaints and referrals. If fraud is detected the case is sent to the State Medicaid Fraud Control Unit or MFCU. Any of these agencies or vendors can do on-site or desk reviews. The reviews can lead to provider education, a recovery, penalties or fines, an exclusion from providing services and/or jail time.

Audits

- Medicaid has the authority to conduct routine audits to monitor compliance with program requirements. Audits may include, but are not limited to:
  - Examination of records;
  - Interviews with providers, their associates, and employees;
  - Interviews with clients;
  - Verification of the professional credentials of providers, their associates and their employees;
  - Examination of equipment, stock, materials, or other items used in or for the treatment of clients;
  - Determination of whether the healthcare provided was medically necessary;
  - Random sampling or claims submitted by and payments made by providers; and/or
  - Audit of facility financial records for reimbursement
  - Actual records reviewed may be extrapolated and applied to all services billed by the provider.

Audits (con't)

The provider must grant the State and it's representative's access during regular business hours to examine medical and financial records related to healthcare billed to the program. Medicaid reserves the right to make unscheduled visits i.e., when a client's health may be endangered, when criminal/fraud activities are suspected, etc.

Medicaid is authorized to examine all provider records.

- All eligible clients have granted Medicaid access to all personal medical records developed while receiving Medicaid benefits.
- All providers who have at any time participated in the Medicaid Program, by signing the Provider Agreement, have authorized the State and their designated agents to access the provider's financial and medical records.
- Provider's refusal to grant the State and its representatives access to examine records or to provide copies of records which requested may result in:
  - Immediate suspension of all Medicaid payments.
  - All Medicaid payments made to the provider during the six (6) year record retention period for which records supporting such payments are not produced shall be repaid to the Division of Healthcare Financing after written request for such repayment is made.
  - Suspension of all Medicaid payments furnished after the requested date of service.
  - Reimbursement will not be reinstated until adequate records are produced or are being maintained.
  - Prosecution under the Wyoming Statute.

What to do if you are audited?

- When a payer audits you the first thing to do is respond to the audit in a timely manner. Do not ignore it; it won't go away. In the initial state of the audit, they will probably ask you to send them your clinical assessment, treatment plan, progress notes and other documentation depending on the type of audit. Send whatever information is necessary to communicate the complete patient situation.
- Keep the following in mind:
  - Do not alter or add to your notes or records in any way.
  - Send your notes by certified mail, return receipt requested, to ensure that the carrier has received it and to prove that you sent it. Failure to send your notes could result in a payment suspension, subpoena or an assumption that you have no records.
  - Only send notes pertaining to the specific time frame that is being audited and any supporting documentation necessary to help establish the need for the care billed.
  - Once you have sent the requested information, there is nothing more to do but go back to work and wait for a response.

Provider Responsibilities

Wyoming Medicaid Provider Manual, Section 3.11 Record Keeping, Retention and Access

- **3.11.1 Requirements**

The Provider Agreement requires that the medical and financial records fully disclose the extent of services provided to Medicaid clients. The following elements include but are not limited to:

- The record must be types or legibly written.
- The record must identify the client on each page.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered into record. For any drugs administered, the NDC on the product must be recorded, as well as the lot number and expiration date.
- The record must indicate the observed medical condition of the client, the progress at each visit, any change in diagnosis or treatment, and the client's response to treatment. Progress notes must be written for every service, including but not limited to: office, clinic, nursing home, or hospital visits billed to Medicaid.
- Total treatment minutes of the client, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented separately, to include beginning time and ending time for billed services.

Note: Additional documentation requirements are in the provider type of the manual.

Provider Responsibilities (con't)

- **3.11.2 Retention of Records**

The provider must retain medical and financial records, including information regarding dates of service, diagnoses, and services provided, and bills for services for at least six (6) years from the end of the State fiscal year (July through June) in which the services were rendered. If an audit is in progress, the records must be maintained until the audit is resolved.

- **3.11.3 Access to Records**

Under the Provider Agreement, the provider must allow access to all records concerning services and payment to authorized personnel of-Medicaid, CMS Comptroller General of the United States, State Auditor's Office (SAO), the Office of the Inspector General (OIG), the Wyoming Attorney General's Office, the United States Department of Health and Human Services, and/or their designees. Records must be accessible to authorized personnel during normal business hours for the purpose of reviewing, copying and reproducing documents. Access to the provider records must be granted regardless of the providers continued participation in the program. In addition, the provider is required to furnish copies of claims and any other documentation upon request from Medicaid and/or their designee.

Best Practices

- GOOD POLICY
- Implement a compliance program
- Train staff and employees
- WIDE – Write It Down Everyday

Good Policy – It all begins with good policy. Follow all Federal and State Statutes, rules, regulations, policies and procedures. (It is your responsibility as a provider to review manuals quarterly for updates and to keep abreast of all changes.

Implement a Compliance Program - Carefully constructing and following a compliance plan is the best thing you can do. This plan includes an annual internal audit. It is even better if that audit is being done by a Certified Compliance Specialist. Remember a compliance plan is only effective if it is appropriately adhered to.

Training Staff and Employees – Staff needs to be trained on all aspects of financial and medical records and documentation standards. Regular training can reduce stress and provide your staff confidence in all compliance procedures.

WIDE – Write it down everyday – double check your documentation to ensure it is complete and complies with all standards. If possible ask a supervisor to review it as well.