

NORTH CAROLINA'S MEDICAID AUDIT EXPERIENCE

September 3, 2013

Presented by:

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WHY ALL THE OVERSIGHT?

> The "F" Word



WHAT IS A RAC?

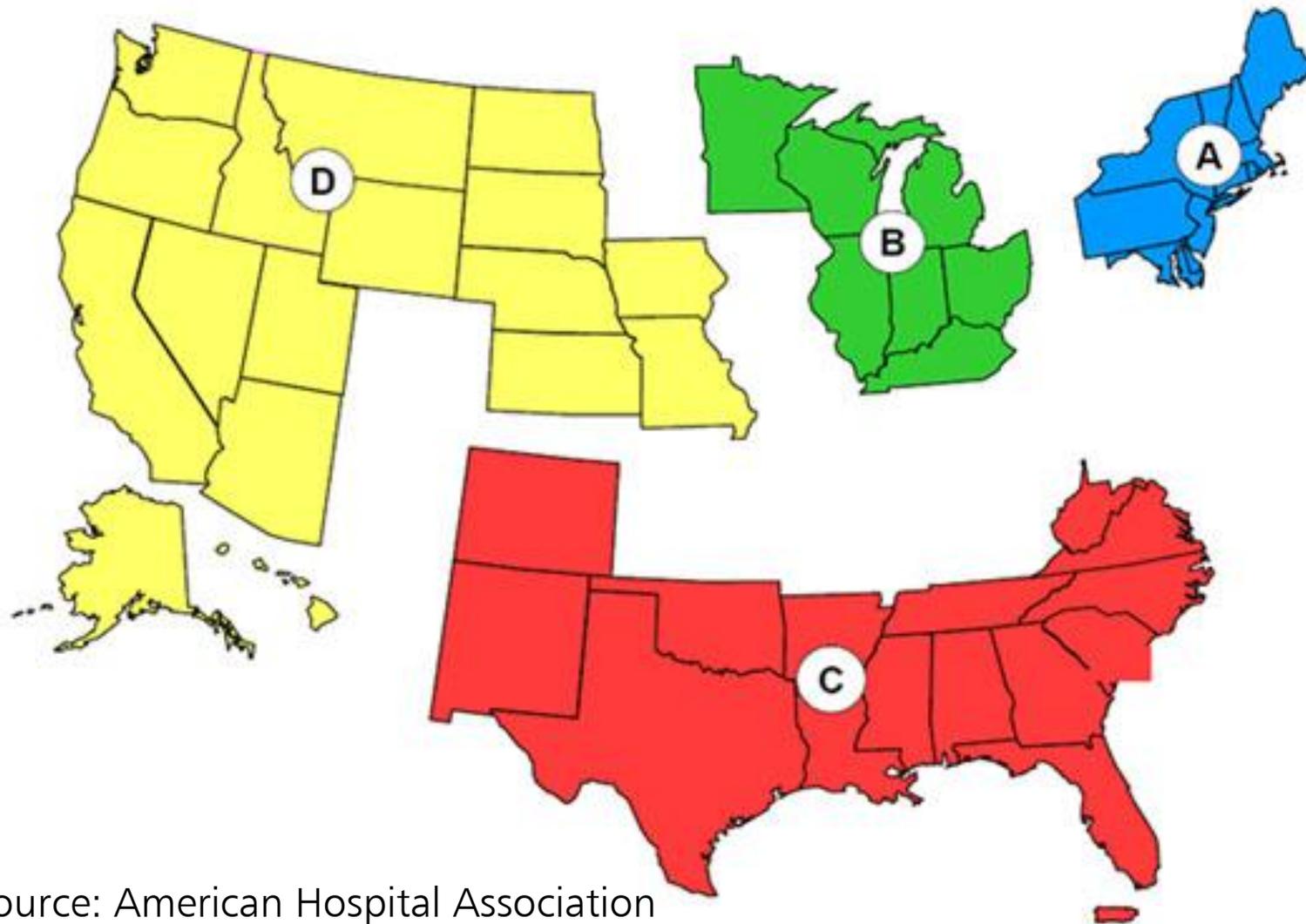
> New under Affordable Care Act

- The Medicaid RACs - Recovery Auditor Contractors

> Let's first understand the Medicare RAC program.

- States were required to establish programs in which they would contract with 1 or more Medicaid RACs by December 31, 2010.
- Medicaid RACs are tasked with reviewing Medicaid claims submitted by providers of services for which payment is made under 1902(a) of the SSA or a waiver of the State plan.

THE FOUR RAC REGIONS



*Source: American Hospital Association

RAC EFFECTIVENESS IN MEDICARE

- > RACs have recovered over \$1.03 billion in overpayments. (DHHS, OIG "RAC Fraud Referrals")
- > CMS estimates that the RAC demonstration program costs approximately 20¢ for each dollar returned to the Medicare Trust Funds. (CMS "Evaluation of the Three-Year Demonstration")
- > Section 302 of the Tax Relief and Health Care Act of 2006
 - Made the RAC program permanent and required nationwide expansion by 2010
 - Medicare RAC program now operational nationwide

RELEVANT AUDIT LAWS

> 42 CFR Parts 405, 424, 447, 455, 457 and 498

> Medicare

- Recovery Audit Contractors (RACs)
- Program Safeguard Contractors (PSCs)
- Zone Program Integrity Contractors (ZPICs)

> Medicaid

- Medicaid Integrity Contractors (MICs)
- RACs

MEDICAID RACs PROGRAM

Definitions:

Medicaid RAC program means a recovery audit contractor program administered by a State to identify overpayments and underpayments and recoup overpayments.

Medicare RAC program means a recovery audit contractor program administered by CMS to identify payments and overpayments and recoup overpayments.

RACs IN MEDICAID

- > Section 6411(a) of the Affordable Care Act expanded RAC to Medicaid and required each State to begin implementation by January 1, 2012.
 - Identification of overpayments and underpayments
 - States & RAC vendor must coordinate the recovery audit efforts
 - RAC vendors reimbursed through contingency model

WHY RACs? (DO WE HAVE TO?)

- > On September 16, 2011, the federal Centers for Medicare & Medicaid Services (CMS) published the *Final Rule for Medicaid Recovery Audit Contractors (RAC)*.
- > Under the Medicaid RAC program, States must enter into contracts consistent with State law in accordance with 42 CFR subpart F with one or more eligible Medicaid RACs to perform post-payment audits in order to identify Medicaid payments that may have been underpaid or overpaid.
- > RACs must follow federal and state guidelines to recover overpayments or inform the N.C. Division of Medical Assistance (DMA) of underpayments.

MEDICAID RACs



RAC AUDITS: KEY ISSUES

- > Three-year look-back period
- > Registered nurses or therapists are required to make determinations regarding medical necessity, and certified coders are required to make coding determinations.
- > RACs are not entitled to keep their contingency fees if a denial is overturned on appeal.
- > Appeal Rights, 42 CFR 455.13

NC NEW MEDICAID AUDITORS

> Public Consulting Group (PCG)

- October 2012
- Fee For Service Claims

> HMS

- October 2012
- inpatient and outpatient hospital, long-term care, laboratory, x-ray and specialized outpatient therapy claims

PUBLIC CONSULTING GROUP

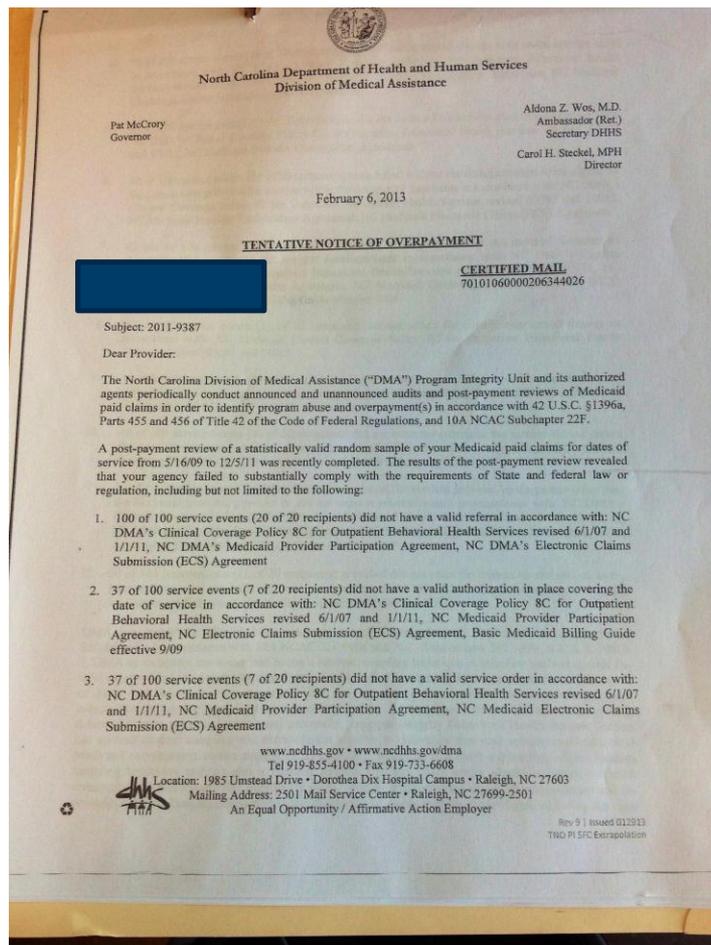


SAME AS NEW MEXICO

PUBLIC CONSULTING GROUP

- > Public Consulting Group (PCG) provides industry-leading management consulting and technology to help public sector education, health, human services, and other government clients achieve their performance goals and better serve populations in need.

TENTATIVE NOTICE OF OVERPAYMENT



TENTATIVE NOTICE OF OVERPAYMENT



Public Focus. Proven Results™

www.publicconsultinggroup.com

8/17/2012

TENTATIVE NOTICE OF OVERPAYMENT

Valid sample of your Medicaid paid claims for dates of service from 11/1/2009 to 4/30/2010

DELAWARE DELTA COMMUNITY SUPPORT GROUP:

The North Carolina Division of Medical Assistance ("DMA") Program Integrity Unit and its authorized agents periodically conduct announced and unannounced audits and post-payment reviews of Medicaid paid claims in order to identify program abuse and overpayment(s) in accordance with 42 U.S.C. §1396a, Parts 455 and 456 of Title 42 of the Code of Federal Regulations and 10A NCAC Subchapter 22F. Public Consulting Group, Inc. (PCG) is a post-payment claims review contractor for DMA.

A post-payment review of a statistically valid random sample of your Medicaid paid claims for dates of service from 11/1/2009 to 4/30/2010 was recently completed. The results of the post-payment review revealed that your agency failed to substantially comply with the requirements of State and federal law or regulation including but not limited to the following:

Community Support Team:

- 28 of 100 records provided by your agency lacked valid Authorizations or had no Authorizations in accordance with Clinical Policy 8A (Community Support Team), Utilization Management;
- 21 of 100 records provided by your agency lacked valid Service Orders or had no Service Orders in accordance with Clinical Policy 8A (Community Support Team), Service Orders;
- 20 of 100 records provided by your agency lacked a valid Person-Centered Plan for the billed date of service or had no Person-Centered Plan in accordance with Clinical Policy 8A (Community Support Team), Required Components;
- 100 of 100 records provided by your agency did not show that the staff has all experience/education/training required to provide the service billed in accordance with Clinical Policy 8A (Community Support Team), Provider Staff Qualifications and 10A NCAC 27G.0104;
- 71 of 100 records provided by your agency indicated that consumer(s) did not meet Entrance Criteria based on the Comprehensive Clinical Assessment in accordance with Clinical Policy 8A (Community Support Team), Service Definition, Entrance Criteria;
- 3 of 100 consumers served by your agency did not have individualized Person-Centered Plans in accordance with the DMH/DD/SAS Person-Centered Instruction Manual;
- 10 of 100 consumers served by your agency did not have a Crisis Plan which included the required elements in accordance with the DMH/DD/SAS Person-Centered Instruction Manual;
- 26 of 100 records provided by your agency did not contain documentation that supported the units billed in

EXTRAPOLATION

\$23,462.40

DMA has tentatively identified the total amount of improperly paid claims to be \$23,462.40. In accordance with 10A NCAC 22F.0606 and N.C. Session Law 2011-399, N.C.G.S. 108C-5, DMA or its agents are authorized to use a random sampling technique to calculate and extrapolate the total overpayment whenever a Medicaid provider fails to substantially comply with the requirements of State and federal law or regulation. You may challenge the determination of substantial non-compliance during the appeal process described below. In the event that you do not challenge this determination or your challenge is not successful, Public Consulting Group has utilized random sampling and extrapolation in order to determine that your agency received a total Medicaid overpayment in the amount of \$418,024.00. Attached is a short explanation of the random sampling technique utilized and a detailed adverse findings chart which identifies the reason each reviewed claim was found to be improperly paid. For more information regarding extrapolation and the procedures for challenging extrapolation and the results of audits that are extrapolated, including the right of providers in the limited and moderate risk categories to conduct a self audit, please refer to N.C. Session Law 2011-399, N.C.G.S. §108C-5(n).

\$418,024.00

EXTRAPOLATION

recipient's diagnosis, functional, and intellectual needs in accordance with Clinical Policy 8A (Community Support), Service Definition and Required Components;

- 49 of 100 consumers served by your agency did not have a Crisis Plan which provided complete guidance in supporting the recipient throughout a crisis in accordance with the DMH/DD/SAS Person-Centered Instruction Manual;
- 2 of 100 consumers served by your agency did not have individualized crisis plans in accordance with the DMH/DD/SAS Person-Centered Instruction Manual;

\$13,442.58

For more specific details related to these findings, please see the attached review tools for each report reviewed.

DMA has tentatively identified the total amount of improperly paid claims in the sample to be **\$13,442.58**. In accordance with 10A NCAC 22F.0606 and N.C. Session Law 2011-399, N.C.G.S. 108C-5, DMA or its agents are authorized to use a random sampling technique to calculate and extrapolate the total overpayment whenever a Medicaid provider fails to substantially comply with the requirements of State and federal law or regulation. You may challenge the determination of substantial non-compliance during the appeal process described below. In the event that you do not challenge this determination or your challenge is not successful, Public Consulting Group has utilized random sampling and extrapolation in order to determine that your agency received a total Medicaid overpayment in the amount of **\$702,611.00**. Attached is a short explanation of the random sampling technique utilized and a detailed adverse findings chart which identifies the reason each reviewed claim was found to be improperly paid. For more information regarding extrapolation and the procedure for challenging extrapolation and the results of audits that are extrapolated, including the right of providers in the limited conduct a self audit, please refer to N.C. Session Law 2011-399, N.C.G.S. §108C-5(n).

\$702,611.00

You may request a reconsideration review of this tentative decision in accordance with 10A NCAC 22F .0402. The request for reconsideration review must be submitted within fifteen (15) working (business) days of receipt of this letter. If you choose to request a reconsideration review, please return the enclosed request form to:

Chief Hearing Officer
DHHS Hearing Office
2501 Mail Service Center
Raleigh, North Carolina, 27699-2501

Attention: PI Case #: 20113992

KEY ISSUES IN TNO

> Sample Size (Usually over 100)

> Payable Immediately

> Appeal:

- Extrapolation?
- Audit?
- Informal?
- Office of Administrative Hearings?



HAVE PCG AUDITS BEEN ACCURATE?

Examples of PCG Blunders:
From Real Life Experience

TOP 10 PCG BLOOPERS



NUMBER 1: WRONG POLICY

2008

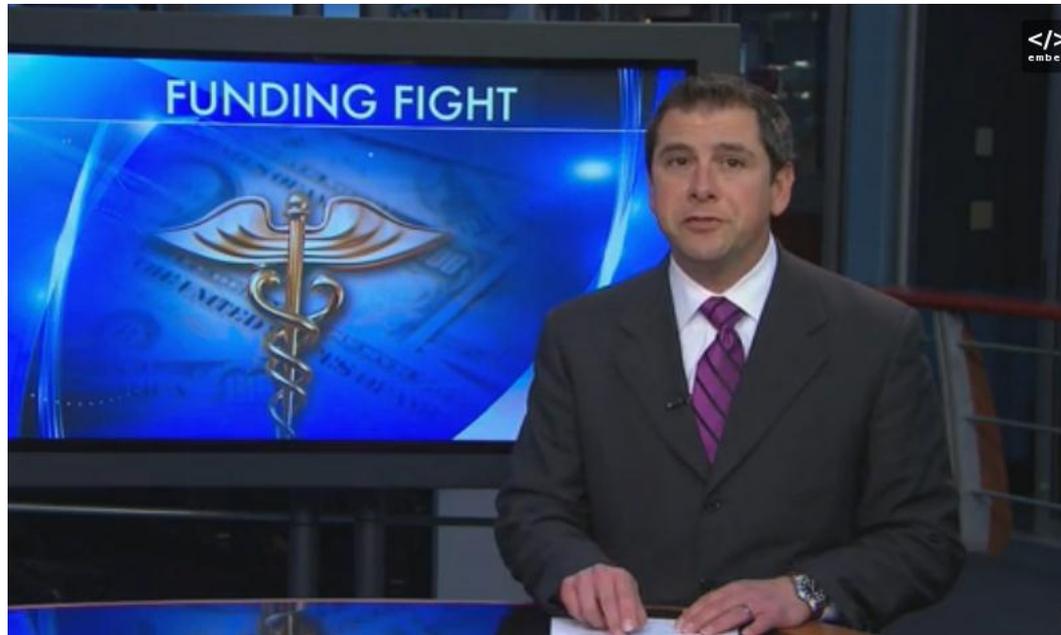
Enter the *attending provider's* NPI for the individual dentist rendering service. (This number should correspond to the signature in field 53.)

2013

Enter the *attending provider's* NPI for the individual dentist rendering service. (This number must correspond to the signature in field 53.)

NUMBER 2: CANNED REQUESTS

<http://www.wral.com/news/local/video/12201117/>



NUMBER 3: NO TRAINING

- > Bachelor's degree in any field
- > Two+ years paid experience working with critical care providers, public health providers, or providers...
- > One year of the experience must have included provider monitoring, Medicaid or third party payer provider billing, or provider training
- > One year of the experience must have been in a home health program, community health program, hospital, private practice, publicly-funded institution...
- > Auditing experience a plus
- > Public sector experience a plus

NUMBER 4: NO COMMUNICATION

- > Provider: I am calling to try to find out why PCG determined all these claims were noncompliant.
- > PCG: Refer to DMA website, policy ____.
- > Provider: Ok. But what about Medicaid Recipient A, DOS X. We followed the policy.
- > PCG: Refer to DMA website, policy __.

NUMBER 5: THAT'S NOT REQUIRED!

- > Denial: No prior authorization.
- > Outpatient Behavioral Therapy (OBT) allows 16 unmanaged visits for children.
- > PCG reviews an unmanaged OBT visit (no prior auth is required) and holds claim noncompliant for lack of prior auth....WHAT?

NUMBER 6: THREE YEAR LIMIT!

- > Date of Audit: March 5, 2013
- > Date of Service: February 2, 2010
- > 42 C.F.R. 455.508 (f), "The entity must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State. "

NUMBER 7: NO MEDICAL NECESSITY

- > Assertive Community Treatment Team (ACTT)
- > No medical necessity found (despite prior authorization) due to provider not exhausting lesser services before requesting ACTT

NUMBER 8: LACK OF CONSENT

- > PCG cites noncompliance due to “lack of signed consent” by the Medicaid recipient.
- > Recipient is 10. Mother signed the consent.
- > But mother has a different last name than child.

NUMBER 9: EXTRAPOLATION ERRORS

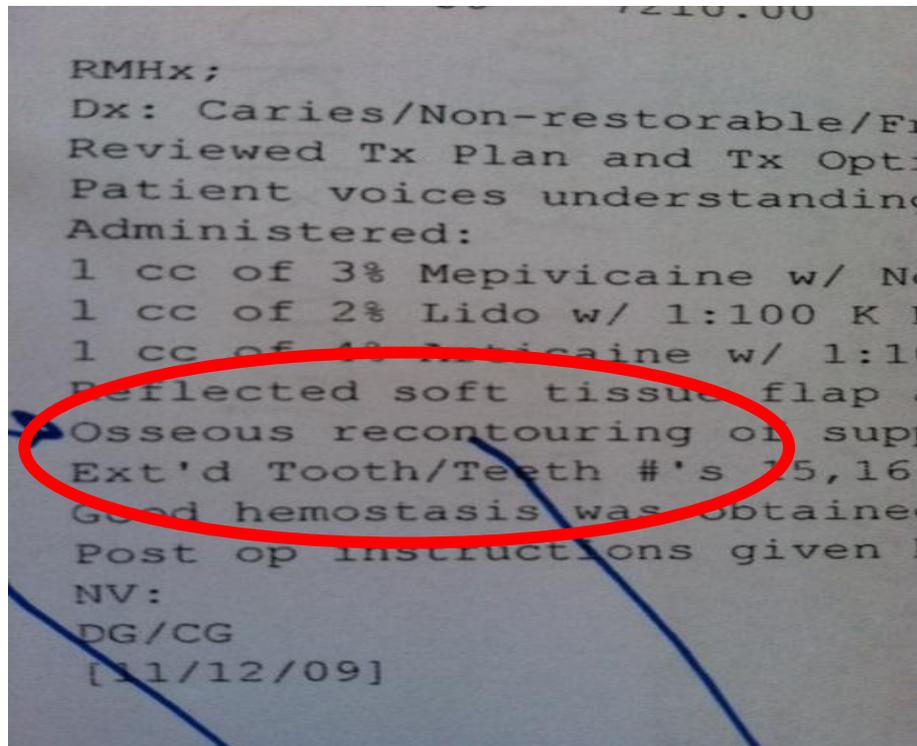
> Clusters

> Modification/Reductions Change the Extrapolation Data

- 1) **Random sampling of provider claims** – Audit of 150 randomly sampled claims that were submitted by the providers. The sampling methodology allows for a statistically valid extrapolation of the findings.

NUMBER 10: MEDICAL JARGON

- > In a PCG audit for a dental provider, PCG cited that the CDT code was incorrect because there was no evidence of shaving or restructuring the bone on the service note.



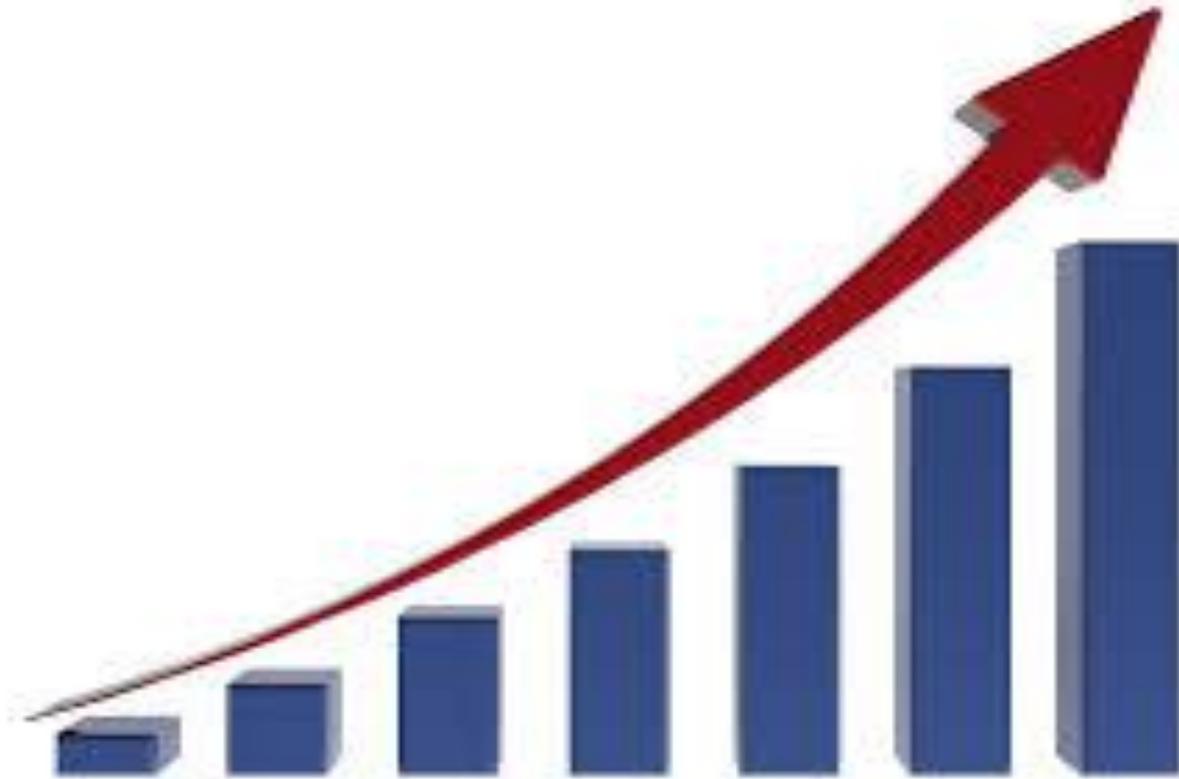
RMHx;
Dx: Caries/Non-restorable/Fr
Reviewed Tx Plan and Tx Opti
Patient voices understanding
Administered:
1 cc of 3% Mepivacaine w/ No
1 cc of 2% Lido w/ 1:100 K E
1 cc of 4% Articaine w/ 1:10
Reflected soft tissue flap a
Osseous recontouring of supp
Ext'd Tooth/Teeth #'s 15, 16,
Good hemostasis was obtained
Post op instructions given b
NV:
DG/CG
[11/12/09]

NUMBER 11: CPT CODE CONFUSION

- Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.

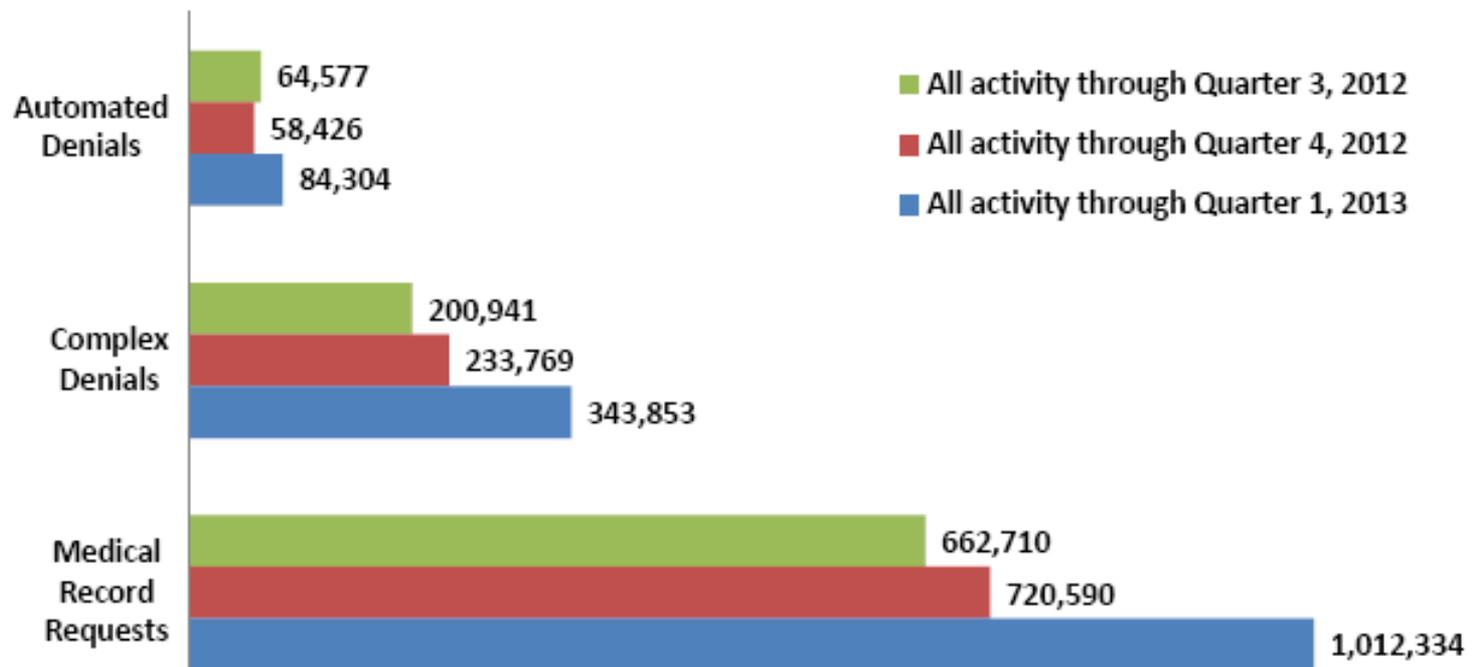
90806 Individual therapy 45 – 50 min

ADMINISTRATIVE BURDEN



PARTICIPANTS CONTINUE TO REPORT DRAMATIC INCREASES IN RAC DENIALS AND MEDICAL RECORD REQUESTS.

Reported Automated Denials, Complex Denials and Medical Records Requests
by Participating Hospitals, through 1st Quarter 2013*



*Source: American Hospital Association, RACTRAC Survey, 1st Quarter 2013

ADMINISTRATIVE BURDEN

Of all hospitals managing the RAC process*
during the 1st quarter of 2013,

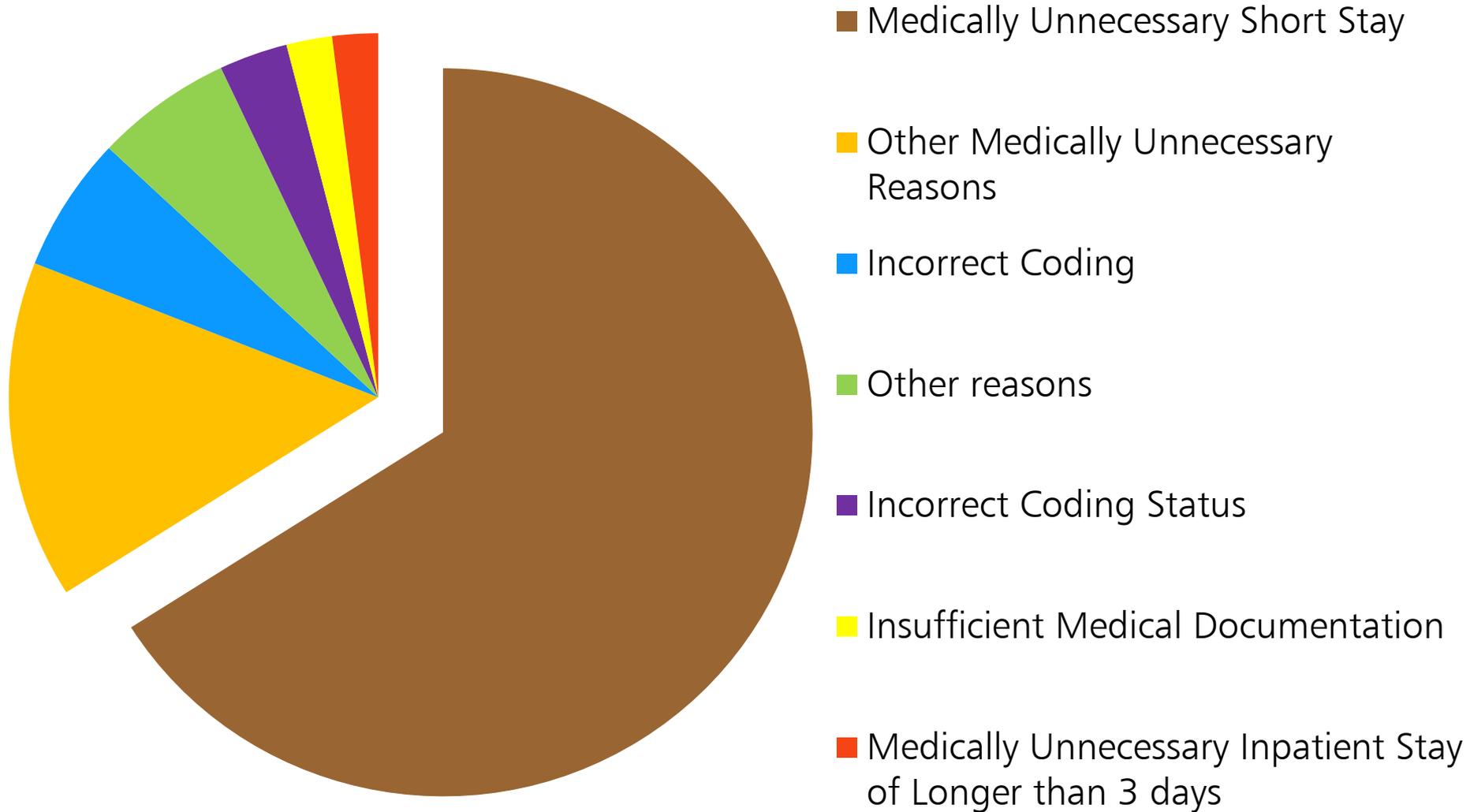
63% spent more than \$10,000,

46% spent more than \$25,000,

10% spent more than \$100,000

*Results of AHA RACTRAC Survey, 4th Quarter 2012

MEDICARE RAC DENIALS*



MEDICARE RAC DENIALS*

- > 94% of hospitals indicated medical necessity denials were the most costly complex denials.
- > 68% of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was medically unnecessary.

*Results of AHA RACTRAC Survey, 4th Quarter 2012

AUDIT RECOMMENDATIONS, CONT.

Appeal!
Appeal!
Appeal!



42 CFR 455.13

Medicaid RAC provider appeals.

States **must** provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination.

ARE APPEALS FRUITFUL?

Yes!

A green pencil is shown drawing the word "Yes!" in a bold, black, sans-serif font on a white surface. The pencil is positioned diagonally, with its tip pointing towards the bottom right, and the word is written along its path. The pencil's body is a vibrant green, and its eraser is visible at the top right.

APPEAL SUCCESS RATES

	Appeals	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Percent of Appealed Denials Overturned
Nationwide	160,747	44%	122,437	72%
Region A	42,158	51%	10,107	79%
Region B	33,315	45%	23,097	79%
Region C	60,849	39%	46,876	76%
Region D	52,749	48%	43,357	60%

*Results of AHA RACTRAC Survey, 4th Quarter 2012

72 % APPEAL SUCCESS

Of the claims that have completed the appeals process, 72% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 1st Quarter 2013*

	Completed Appeals					
	Appealed	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Number of Denials Not Overturned from Appeals Process (Withdrawn/Not Continued)	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned (as a Percent of Total Completed Appeals)
NATIONWIDE	160,747	44%	122,437	10,537	27,595	72%
Region A*	42,158	51%	10,107	799	2,926	79%
Region B	33,315	45%	23,097	2,153	8,007	79%
Region C	60,849	39%	46,876	3,404	10,495	76%
Region D	52,749	48%	42,357	4,181	6,167	60%

**Manual survey entries only for Region A. Due to survey submission error, total appeals may be greater than the sum of pending/withdrawn/overturned appeals.

*Response rates vary by quarter.

Source: AHA. (April 2013). RACTRAC Survey

AHA analysis of survey data collected from 2,380 hospitals: 2,060 reporting activity, 320 reporting no activity through March 2013. 1,324 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

© American Hospital Association



MEDICAID APPEAL PROCESS

- > Informal reconsideration review (15 days)
- > Attend reconsideration review at DMA
- > DHHS Hearing Officer Decision
- > Appeal Decision to Office of Administrative Hearings (OAH)
(60 days)
- > Notice of Contested Case Hearing

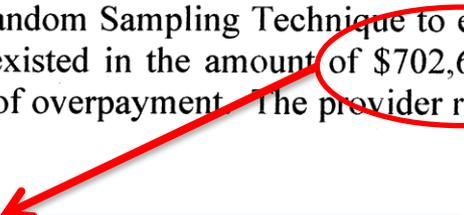
MEDICAID APPEAL PROCESS

- > Mandatory Mediation (Impasse)
- > Extrapolation Expert
 - Challenge Sample Size
 - Challenge Clusters
 - Challenge Modified Extrapolation
- > OAH Hearing
- > Judicial Review, if necessary

EXAMPLE OF OUR SUCCESS

BACKGROUND INFORMATION

In a letter dated March 4, 2013, Public Consulting Group (PCG), which is under contract with the NC Division of Medical Assistance (DMA) to conduct post-payment reviews and audits of Medicaid claims, notified Melange (“the provider”) that a post-payment review of a statistically valid random sample of its Medicaid paid claims for Community Support Services revealed documentation deficiencies and/or program errors. After applying a Disproportionate Stratified Random Sampling Technique to extrapolate the total overpayment, PCG determined that an overpayment existed in the amount of \$702,611.00. A copy of PCG’s audit tool findings was included with the notice of overpayment. The provider requested a reconsideration review of this determination.



From \$702,611.00, to...

DECISION

...to \$336.84

DECISION

Based on the above-findings I modify the recoupment from the original amount of \$702,611.00 to the revised amount of **\$336.84**.

EXAMPLE OF OUR SUCCESS



NORTH CAROLINA INJUNCTIONS

- > Judge Ordered DHHS/contracted company to STAY the suspension of Medicaid reimbursements pending litigation.
- > Judge Ordered MCO to STAY its refusal to contract with a provider pending litigation.
- > Judge Ordered DHHS to STAY its termination of provider from Medicaid program pending litigation.
- > Judge Ordered MCO to STAY all determinations of medical necessity pending litigation.

NEW MEXICO STATUTES 27-11-3

- > New Mexico Statutes 27-11-3. Review of Medicaid providers; contract remedies; penalties
- > C. Subject to the provisions of Subsection D of this section, after affording a Medicaid provider written notice of hearing not less than ten days before the hearing date
- > and an opportunity to be heard,
- > and upon making appropriate administrative findings,

NEW MEXICO STATUTES 27-11-3

- > (1) impose an administrative penalty of not more than five thousand dollars (\$5,000) for engaging in any practice described in Paragraphs (1) through (6) of Subsection B of this section; provided that each separate occurrence of such practice shall constitute a separate offense;
- > (3) suspend or revoke the contract between the provider and the department pursuant to the terms of that contract.

- > D. If a contract between the department and a Medicaid provider explicitly specifies a dispute resolution mechanism for use in resolving disputes over performance of that contract, the dispute resolution mechanism specified in the contract shall be used to resolve such disputes in lieu of the mechanism set forth in Subsection C of this section.
- > E. If a Medicaid provider's contract so specifies, the Medicaid provider shall have the right to seek de novo review in district court of any decision by the secretary regarding a contractual dispute.

NEW MEXICO



Thank You