RAC SUMMIT-THE NEW WORLD OF MEDICAID DATA MINING AND MEDICAID INTEGRITY CONTRACTORS

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NEW YORK OFFICE OF MEDICAID INSPECTOR GENERAL

Our mission is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.[1]

[1] *N.Y. Public Health Law § 31.*

“Abuse” & “Improper Payments”

- Abuse
  - “Abuse means practices that are inconsistent with sound . . . medical or professional practices and which result in unnecessary costs . . ., payment for services which were not medically necessary, or payments for services which fail to meet recognized standards for health care.”[1]
  - Similar provisions in other states.
- Improper Payments
  - An improper payment is “any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under . . . legally applicable requirements.”[2]

[1] 18 NYCRR § 515.1(b)(1).

[2] Federal Improper Payments Information Act of 2002; Improper Payments – Progress Made But Challenges Remain In Estimating and Reducing Improper Payments, GAO-09-628T (U.S. Government Accountability Office, April 22, 2009).

Core OMIG Principle: Develop and Use Innovative Data Mining Capabilities

$200 Billion in claims in data warehouse

- End-to-end integration
- Using new databases and analytic tools
- Identify and communicate compliance data analysis processes which will identify problem at source
- Identify and communicate issues discovered through data mining
- Train and equip employees and organizations in data analysis techniques

FREE STUFF FROM OMIG

- OMIG website-WWW.OMIG.State.ny.us
- Mandatory compliance program-hospitals, managed care, all providers over $500,000/year
- Over 1300 provider audit reports, detailing findings in specific industry
- 66 page work plan issued 4/20/09-shared with other states and CMS, OIG (new one coming in April)
- Listserv (put your name in, get emailed updates)
- Updates on Medicaid Integrity Contractors IPRO and Thomson-Reuters
- New York excluded provider list

THE NEW AUDIT LANDSCAPE

- CMS contractors in the current audit landscape
  - Recovery Audit Contractors (RACs)
  - Medicare Administrative Contactors (MACs)
  - Medicaid Integrity Contractors (MICs)
  - Program Safeguard Contractors (PSCs) & Zone Program Integrity Contractors (ZPICs)
  - Quality Improvement Organizations (QIOs)

THE NEW AUDIT LANDSCAPE
Recovery Audit Contractors

RAC Reviews

- Complex Reviews: review of medical records related to claim
  - Employed when it is likely, though not certain, that a service is not covered, **or**
  - There is no Medicare policy, article or sanctioned coding guidelines
  - Medical record limits set by CMS
    - FY 2010 DRG Validation Additional Documentation Limits
    - FY 2009 Medical Record Limits

THE NEW AUDIT LANDSCAPE
Recovery Audit Contractors

RAC Reviews :

- RACs are required to comply with all NCDs (national coverage decisions), coverage provisions in interpretive manuals, national coverage and coding articles, LCDs, and local coverage and coding articles in their jurisdiction

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- June 2005 study by the Government Accountability Office ("GAO") emphasized the lack of resources towards Federal oversight of the Medicaid programs.

- Section 6034(e)(3) of the Deficit Reduction Act 2005 mandated the creation of the Medicaid Integrity Program (MIP)
  - Under MIP, CMS will hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues
  - CMS will support and assist the states in their efforts to combat Medicaid fraud and abuse

THE NEW AUDIT LANDSCAPE
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THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- MIP was operated under the jurisdiction of the Center for Medicaid & State Operations (CMSO);as of spring, 2010, it was moved to the Center for Program Integrity under Deputy Administrator Peter Budetti. This Center will administer both Medicare and Medicaid program integrity activities
- The Medicaid Integrity Group (MIG), soon, the Medicaid Program Integrity Group("MPIG") was created to implement and manage the MIP
- MIG includes three divisions:
  - Division of Medicaid Integrity Contracting (DMIC)
  - Division of Fraud Research and Detection (DFRD)
  - Division of Field Operations (DFO)

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- There are 3 types of MIC Contracts:
  - Review MICs
  - Audit MICs
  - Education MICs
- MIC task orders are awarded for 12 month periods and can be renewed for an additional 12 month period up to four times
- All task orders have now been awarded

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Review MICs**
  - Review and select providers for audit using algorithms to analyze electronic claim data for aberrancies
  - Unlike the RACs, the MICs are not restricted on how far they can look back to identify overpayments

- State agencies may also identify providers to be audited

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Audit MICs**
  - Once selected by the Review MIC, the provider is referred to the Audit MIC
  - The Audit MIC will send the provider a notification letter setting forth the records requested
    - Notification letter will also identify a primary point of contact at the Audit MIC to answer specific questions about the audit
  - The Audit MIC is responsible for setting up an Entrance Conference with the provider

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Audit MICs**
  - Audit MICs may
    - Perform desk or field audits
    - May interview providers and staff
    - Enter facilities
  - Unlike RACs, Audit MICs do not have medical record request limitations
  - Audit MICs are not paid on a contingency fee basis
  - As of December 2009, audits were underway in 31 states

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Audit MICs**
  - **Audit Report Process**
    - Audit MIC will prepare a draft audit report
    - Draft report is shared with state Medicaid agency to ensure the state's Medicaid policies were interpreted properly
    - Draft report is shared with provider who is given 30 days to comment and submit additional information
    - CMS prepares a second draft report, taking comments into consideration
    - Draft report is again shared with state for comment
    - After taking state's comments into consideration, MIC will submit a final report to the state

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Audit MICs**
  - Audit MICs are **not** tasked with collecting overpayments
  - Federal government collects its share directly from the state and the state is responsible for recovering the overpayment from the provider
  - Like the RAC program, payments to providers may be recouped once an overpayment is identified. Not so fast...

THE NEW AUDIT LANDSCAPE
Medicaid Integrity Contractors

- **Education MICs**
  - Education MIC task order was awarded Strategic Health Solutions LLC in September 2009
  - Education MICs selected, not yet operating
  - Began with survey of state agencies, other stakeholders
  - Education will likely take the form of distributing educational materials, classroom education opportunities and awareness campaigns
  - Focus of education will be based on risk areas identified by Audit and Review MICs, as well as OIG, GAO, HHS and state Medicaid Fraud Control Units

MIC AUDITS-RAC "Approved Issues" METHODOLOGY DIFFERS FROM MIC

- concern from the RAC Demonstration Project- whether the RACs properly interpreted Medicare criteria and made accurate overpayment determinations
- In response, CMS created the "new issue review" process and contracted with an independent entity to serve as the RAC Validation Contractor
- process for MICS-Review MICs, reliance on state agency review of draft audit reports

MIC AUDITS

- DISCLOSURE OF MIC AUDIT STANDARDS SPECIFIC TO AUDIT REPORT SUBMITTED TO STATE AND PROVIDER
- RACs are required to comply with all NCDs (national coverage decisions), coverage provisions in interpretive manuals, national coverage and coding articles, LCDs, and local coverage and coding articles in their jurisdiction
- WHAT ARE LIMITS ON MICS? What if oral guidance differs from state plan and written guidance?

SAMPLE AUTOMATED RAC REVIEW- AMBULANCE PART B SERVICES BILLED DURING HOSPITAL STAY

- **Issue Description:** Ambulance services should be billed to the inpatient provider for services for inpatients. Therefore, an issue may exist when a beneficiary received ambulance services during an inpatient stay, which have been billed and reimbursed under Medicare Part B.
- **Type of Review**Automated Review for Overpayments (Error Code: 6000)**State(s) Affected:**DC, CT, MA, ME, DE, NJ, NY, NH, PA, RI, VT**Providers Affected:**Ambulance Providers**Date Posted:**January 07, 2010**Dates of Service:**October 1, 2007 – Present
- **Issue References**Internet Only Manual, Medicare Benefit Policy Manual Publication 100-02 Chapter 10, Section 10 and 10.3.3. Internet Only Manual, Medicare Processing Manual, Publication 100-04, Chapter 3, Sections 10.4 and 10.5. Internet Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 15, Section 10.2, Summary of Benefit and 30.A, Modifier specific to Ambulance Services.

SAMPLE COMPLEX REVIEW: Validation for MS-DRG 189 Pulmonary Edema & Respiratory Failure

- **Issue Description:** DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRG 189, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.
- **Type of Review**DRG Validation (Error Code: 3200, 3300)
- **Providers Affected:**Inpatient Hospitals
- **Date Posted:**January 19, 2010
- **Issue References**ICD-9-CM Coding Manual (for dates of service on claim), ICD-9-CM Addendums and Coding Clinics, PIM Ch 6.5.3, Section A - C - DRG Validation Review, OIG Report DRG 87: Pulmonary Edema and Respiratory Failure, August 1989
- WHY?
- $1 billion in Medicare expenditures for this code in 2008; similar to lower weighted DRGs (pneumonia, pleural effusion)

Validation for MS-DRG 189

- **Principal Diagnosis Codes That Commonly Group To Drg 189**
- 506.1 - Acute pulmonary edema due to fumes and vapors
- 514 - Pulmonary congestion and hypostasis
- 518.4 - Unspecified acute edema of lung
- 518.5 - Pulmonary insufficiency following trauma and surgery
- 518.81 - Acute respiratory failure
- 518.83 - Chronic respiratory failure
- 518.83.1 - Acute and chronic respiratory failure

MIC CONTRACTOR FINDINGS

- Effect of findings against safety net providers-state law requires consideration of best interest of beneficiary and program-no such requirement for MIC
- Effect of finding against state-collection unless provider is bankrupt
-

Waiver of Liability by statute not available in Medicaid

- Section 1879(a) of the Social Security Act
- Under waiver of liability, even if a service is determined not to be reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

Unlike Medicare, "Provider Without Fault" defense not available by statute

- Section 1870 of the Social Security Act
- Once an overpayment is identified, payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services
  - Definition of fault
  - 3 Year Rule

LITIGATING MIC FINDINGS
The Medicaid Appeals Process

- Provider appeals of MIC audits will be handled pursuant to state law.
- The appeal processes for the various states differ. Some are governed by the state's administrative procedures act, others have area specific regulations. Some will contain an opportunity for a hearing before an ALJ (NY); some provide for review of the written record (Tx.); some must be challenged in state court (Ct.)

THE MEDICAID APPEALS PROCESS
New York

- OMIG monitors NY Medicaid Program
  - Conduct audits
  - Seek restitution for improper payments
- If overpayments are found, OMIG will hold an exit conference, hear the provider's response, will then issue a draft audit report, setting forth the items disallowed and the OMIG's proposed action
  - Providers have 30 days to submit documentation and/or object to the proposed action
  - After consideration, OMIG will issue a final audit report
  - Provider may request an administrative hearing to contest an adverse determination

THE MEDICAID APPEALS PROCESS
New York

- Hearing under Administrative Procedures Act
  - Opportunity for a hearing
    - Present written arguments
    - Present oral argument
  - Complete record of proceeding
    - All records and documents in possession of the agency must be offered and made part of the record
  - Final determination
    - Each agency maintains an index by name and subject of determination
    - Article 78 Appeal to NY Supreme Court

THE MEDICAID APPEALS PROCESS
New York

- Withhold of Payments
  - At option of OMIG, overpayments may be recovered by withholding provider's or affiliate's billings
  - DOH may withhold payment in absence of a final audit report when it has reliable information that the person is involved in fraud or willful misrepresentation
  - Withhold will not typically continue for more than 90 days unless a report or notice of agency

Requests for Information

- Requests for information can prove helpful in both Medicare and Medicaid appeals
  - State and Federal Freedom of Information Acts
    - Requests to contractors, carriers, QICs
  - Request for audit file from ALJ
  - Discovery rules

THE MEDICAID APPEALS PROCESS Texas

- Texas Medicaid Program is operated under the Health and Human Services Commission (HHSC)
- Provider Appeals
  - Request for review of (not a hearing on) denied claims
    - Technical, non-medical denials
    - Medical necessity denials

THE MEDICAID APPEALS PROCESS Texas

- Providers must submit additional information requested by HHSC within 21 calendar days or case will be closed.
- A determination will be reached within 90 days of the date a complete request for appeal is received.
- Determination is a final decision for administrative claims and medical appeals.

CONCLUSION

- How will merger of Medicare and Medicaid program affect differing standards for RAC and MIC programs?
- How much deference will CMS give to state agency judgment in selection of audit targets, analysis of applicable rules, support of audit findings?
- What volume of results will we see from MIC audit work?