

The Medicaid Integrity Program: A New Risk Area for Providers

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Just as Michigan providers are bracing for the upcoming onslaught of Medicare RAC audits, providers must also prepare for an increase in Medicaid audit activity as a result of the Medicaid Integrity Program (MIP).

The Deficit Reduction Act (DRA) of 2005 established the MIP, which is the first federal program to perform Medicaid provider audits. Similar to the Medicare RAC program, the MIP requires the use of contractors to target providers through the use of statistical data, to audit provider claims and identify potential overpayments, as well as to provide education. These contractors are known as Medicaid Integrity Contractors (MICs). While a MIC contract has not yet been awarded for Region V, which includes Michigan, contracts have been awarded in at least four other regions and the program is expected to be fully operational nationwide by 2010. Three types of MIC contracts will be awarded: Medicaid Integrity Review Contracts (Review MICs), Medicaid Integrity Audit Contracts (Audit MICs), and Medicaid Integrity Education Contracts (Education MICs).

Review MICs will conduct data analysis utilizing algorithms pursuant to oversight by the Division of Fraud Research and Detection (DFRD) to analyze Medicaid claims for aberrancies. This information will be shared with the Audit MIC to assist the Audit MIC with targeting providers who may pose a risk to the Medicaid program. As has been the case historically, state agency officials may also identify providers.

Once providers have been identified by the Review MIC or a state official, the Audit MIC will contact providers in writing requesting additional supporting documentation within a specific time frame and will also contact the provider regarding an entrance conference. Audit MICs may conduct both field and desk audits and will review paid claims to ensure that services were actually provided, covered by the Medicaid program, properly documented, properly billed, and paid according to Federal and/or State rules and regulations. Unlike RAC contractors, the Audit MICs will not be paid on a contingency basis. The Audit MICs are also not responsible for collecting overpayments. Rather, the states will be charged with recovering overpayments and the federal government will collect its share from the state.

After the completion of the audit, the Audit MIC is expected to prepare a draft audit report. The report will be shared with the state and then the provider, both of whom will have an opportunity to review and comment on the findings. CMS will take these comments into consideration and will prepare a draft report, which will again be reviewed by the state for comment. After taking the state's comments into consideration, the Audit MIC will submit a final report to the state. All provider appeals will be handled through the state, with support from the MIC. In Michigan, the appeals process for the adjustment or reduction of provider payments includes the right to a preliminary conference, a bureau conference and an administrative law judge hearing.

Audit MICs are also expected to make referrals to the HHS Office of Inspector General (OIG) if fraudulent behavior is detected. The OIG, where deemed appropriate, will pass this information on to the state's Medicaid Fraud Control Unit. This will likely result in an increase in Medicaid fraud investigations, especially when considered in

conjunction with other components of the DRA, including incentives provided to the states to develop legislation comparable to the Federal False Claims Act. Michigan recently amended its Medicaid False Claim Act to remedy deficiencies noted by the OIG, which is charged with determining whether the law is sufficiently similar to the Federal False Claims Act. This will qualify Michigan for increased recoveries in Medicaid false claim cases, giving the state a greater incentive to vigorously pursue fraud allegations.

According to an April 2009 Government Accountability Office (GAO) report, the Medicaid program reported an estimated error rate of 10.5 percent resulting in a total improper payment estimate of 32.7 billion dollars. Of this estimated 32.7 billion dollars, 18.6 billion dollars represents the federal share and 14.1 billion dollars represents the state share, creating huge incentives for both the state and the federal government to attempt to recover these alleged “improper payments.” Because the estimated overpayments are even greater than those associated with the Medicare program, the MIP has the potential to have an even greater impact on providers than the RAC.

The Education MICs are charged not only with educating providers, but also beneficiaries and others about program integrity. This, combined with the DRA’s other requirements that certain health care providers educate their staff on the whistleblower provisions of the federal and state laws, as well as include this information in employee handbooks, will likely increase the number of qui tam lawsuits alleging Medicaid fraud. The combination of improved regulatory initiatives at the state level and the increased federal government involvement in Medicaid fraud detection and enforcement is expected to significantly increase overall enforcement of Medicaid fraud, so providers need to be prepared.

As with the RAC audits, review by a MIC cannot be prevented. However, providers can take steps to reduce the risk that their claims will be statistical outliers. Providers should conduct self-audits now as part of a comprehensive compliance plan. Self-audits should focus on areas identified by CMS to indicate aberrancies, such as: services dated after death, duplicate claims, unbundling, and outpatient claims during an inpatient stay. Providers should also look at documentation to ensure that it supports medical necessity and the code billed. In addition, providers should put mechanisms in place now in preparation for responding to record requests from the MIC. Such mechanisms should be similar to those put into place to prepare for RAC record requests and might include designation of certain individuals within the organization who are prepared to gather, copy and review information timely in response to requests. If notified of an audit, providers should immediately seek experienced legal counsel to protect their interests, as there are early opportunities to review and comment on the audit report and then to pursue the various levels of the Medicaid appeals process. There are both clinical and legal defenses available in the appeals process that requires working knowledge of the program and the process. As with RAC and other Medicare audits, a strong defense can significantly mitigate a provider's exposure.



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