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TCORS Medicaid Audit Newsletter

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Special points of interest:

- Medicaid RACs Hired on Contingency Basis
- Medically Necessary Reviews
- Minimizing Audit Exposure
- Q&A
- Helpful Hints

RACs for Medicaid: They're Here and Ready to Audit

Section 6411 of the Patient Protection and Affordable Care Act requires states to hire Recovery Audit Contractors (RAC) to audit Medicaid payments made to providers. The Centers for Medicare & Medicaid Services (CMS) has mandated that the RAC program be fully operational by April 1, 2011.

To address this mandate, Connecticut made a change to its Medicaid State Plan which calls for the Department of Social Services (DSS) to hire one or more RACs and pay them a contingency fee based on a percentage of what they collect; in other words, the higher the audit adjustments, the more they get paid.

The contingency fee rate paid by the State will be no less than 10 percent of the amount recovered

and will be capped at the highest Medicare RAC rate in effect at the time of payment, which presently is 12.5 percent.



The audits conducted by the RACs will be in addition to those that are presently being conducted by DSS. The payment of RACs on a contingency basis could result in overly aggressive audit disallowances being taken by the RACs and significant losses by providers subject to these audits. CMS is expecting to recover substantial provider Medicaid payments

from the RAC audit program. The CMS Office of the Actuary has projected the Federal Medicaid savings shown on Table A on page 2.

CMS Administrator Donald Berwick, M.D. states, "We are using many of the lessons that we learned from the Medicare RAC program in the development and implementation of the Medicaid RACs." And despite their own large dollar savings estimates, CMS claims that the Medicaid RACs should have, "A limited financial impact on most providers, as significant improper payments are relatively rare." However, the American Hospital Association's (AHA) November 15, 2010 RACTrac Survey revealed that the Medicare RAC program has had a negative financial im-

Article cont'd on page 2

The Necessity of Medical Necessity

In 2009, Connecticut Public Act 09-3 revised the definition of medical necessity. In October 2010, DSS & DMHAS issued Provider Bulletin 2010-61 notifying providers of their intent to perform post-payment audits of behavioral health services based on this new statutory definition. Although this defini-

tion deals with medical necessity, one of the focuses of this change and of the targeted reviews is to reduce state costs by reducing the level of care for which a provider is being reimbursed.

The first standard listed in the definition, cited as (1)(A) through (1)(D), will be used as

the basis of denial for any case where the services requested do not coincide with "generally-accepted standards" that are found within clinical guidelines such as the Milliman Care Guidelines, or the published opinions of medical experts.

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“Connecticut RACs to be paid on a contingency fee based on a percentage of what they collect.”

RACs for Medicaid (cont'd from page 1)

pact on 72% of 1,700 hospitals and has resulted in increased administrative costs for 51% of the hospitals who responded to the survey. In addition, the AHA, along with the American Academy of Family Physicians, have also expressed a number of concerns with the Medicaid RACs based on their prior experience with Medicare RACs, including: lack of provider education; unbalanced RAC focus on overpayments; medical necessity reviews; duplication of existing audits; excessive medical record requests; lack of transparency and oversight in the RAC program; insufficient RAC medical expertise; and disincentive for RACs to avoid appeals.

Providers need to prepare for these audits and take the necessary steps to protect themselves from unnecessary audit disallowances. The best

method for minimizing disallowances is to have a program in place that ensures compliance with Medicaid regulations and documentation requirements. Whether in-house, contracted, or a combination of the two, providers should be conducting ongoing reviews of their supporting documentation to ensure state Medicaid requirements are adhered to, thus avoiding exposure to audit disallowances.

| TABLE A | |
|----------------------------------|--|
| Fiscal year | Estimated savings (in millions of dollars) |
| 2011 | \$80 |
| 2012 | 170 |
| 2013 | 250 |
| 2014 | 310 |
| 2015 | 330 |
| <i>Projected Federal Savings</i> | |

Providers also need to be aware of their rights if they are subject to a RAC audit. Section 1902 (a)(42)(B)(ii)(III) of the Act requires that “the State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).” In addition to this, section 17b-99 (d) of the Connecticut General Statutes allows providers the right to appeal a final audit decision to the Superior Court (effective July 2010). It is crucial that providers are not only aware of these rights, but also know how and when to use them throughout the audit process.

In summary, the RACs are coming to Connecticut and providers need to be aware and prepared so that they can avoid costly audit disallowances and if audited, effectively dispute any adverse audit findings.

Medical Necessity (cont'd from page 1)

As indicated in the definition under the standards numbered (2), (4), and (5), we believe that these reviews will focus on the individual patient’s treatment plan and progress notes to look for (at a minimum) the type of intervention, frequency of intervention, extent of time, and the duration of services provided (detailing the start and end times of any therapeutic treatments). The levels of care rendered will be analyzed to determine that an individual patient actually needed such treatment. For example, a patient requiring

intensive outpatient services versus regular outpatient services.

In addition, standard number (5) ensures that the provider is supplying medical treatment to its patients based on their individual needs. By reassessing and updating the plan of care and/or treatment plan with the patient on a regular basis, the provider can be sure that they are following an individualized plan for the particular patient and that the patient’s needs and goals are being met within a timely manner.

With the anticipated increase in denials based on the five standards listed in the medical necessity definition, it is imperative that providers adequately document the need for the level of service being provided and billed to Medicaid.

Although PB 2010-61 is addressed to alcohol and drug centers, FQHC, mental health clinics, and hospitals, it is important to note that any Medicaid provider is susceptible to an audit based upon this definition.

The Quiet Budget Cuts

As the State of Connecticut faces unprecedented budget deficits, entitlement programs such as Medicaid will face financial cutbacks. Because these programs constitute a substantial portion of the state budget, making cuts that will adversely affect recipients of these programs is difficult to do, both politically and programmatically. Reducing Medicaid benefits, adding or increasing recipient co-pays, and restricting eligibility are the cuts with the biggest financial bang. However, these types of budget cuts are also the kind that the administration and legislators will be most reluctant to make. Furthermore, there has been a move of late for the federal government to restrict states from changing Medicaid benefit levels and increasing eligibility standards as a condition for accepting increased Medicaid funding, as was done with the

2009-2010 federal stimulus funds that increased the federal share of Medicaid costs. Any restrictions such as these inhibit the state from making the cuts that have the most effect on the budget.

So, how do you cut into the Medicaid budget without making painful choices? You make cuts that are “easy.” In the Medicaid world, this means finding ways to cut the budget on paper that will not affect the recipients and will go almost unnoticed during the budget process. One such method that can result in a direct financial impact upon Medicaid providers is to increase projected audit adjustments on providers, which is factored into the Medicaid budget, thereby resulting in a reduction to the Medicaid expenditure line item. These projections may include an increase in staff assigned to perform the audits

and/or create pressure on those responsible for the audits to increase adjustment amounts.

Providers are already being subject to this trend of silently cutting the budget, as is exemplified by the Centers for Medicare and Medicaid Services’ introduction of the Recovery Audit Contractors to Medicaid. By cutting the budget through the increase in audit adjustment projections and by putting the target on providers, the State will be able to successfully reduce its budget in a hidden manner without adversely affecting Medicaid recipients.

In order to protect themselves under this increased scrutiny, providers must be diligent in ensuring compliance with the Medicaid regulations and documentation standards and, if audited, providers must be cognizant of their rights.

Reducing Audit Exposure: The Rule of Seven

How can a provider reduce its audit exposure to the recapture of Medicaid payments? The general answer to this question is that each provider should adopt and actively implement an appropriate written compliance plan that includes a section on billing protocols and procedures and internal controls for periodically evaluating these protocols and procedures. The concept of compliance plans was kick started in 1991 when the United States Sentencing Commission adopted sentencing guidelines that enable an organization accused of criminally violating requirements of various government programs to reduce its potential fines and penalties by demonstrating that it has an effective compliance program. Such a program must include the following seven core criteria:

1. Written compliance standards and procedures reasonably capable of reducing errors, waste, fraud, and abuse
2. Oversight by high-level personnel
3. Due care in delegating substantial discretionary authority to oversight personnel
4. Effective and periodic communica-

- tion to all levels of employees of compliance standards and procedures
5. Reasonable steps to achieve compliance, which include systems for monitoring, auditing, and reporting activities subject to compliance, the compliance program itself, and seeking confidential input from employees
6. Consistent enforcement of compliance standards including incentives and disciplinary mechanisms
7. Reasonable steps to respond to and prevent further errors or violations

While guidelines listed by the Sentencing Commission were aimed at fraud, tax offenses, antitrust offenses and food and drug violations, the principles of those guidelines have become the framework for compliance programs suggested by many regulatory authorities for a variety of program purposes. For example, in 1997, the Office of Inspector General of the U.S. Department of Health and Human Services began producing specific compliance program guidance for segments of the health-care industry that receive payments funded by federal health care programs. This guidance included suggestions on how providers can design internal controls to monitor

adherence to applicable statutes and regulations and program requirements. Again, while the focus of these guidances has been on reducing provider exposure to potential civil and criminal penalties, an important by-product has been the evolution of compliance programs that include controls and procedures to enhance compliance with coding, billing and documentation requirements in order to reduce billing errors. A further catalyst to compliance programs is the Deficit Recovery Act of 2006 which requires providers who receive annual payments of \$5 million or more from the state to adopt written policies that detail procedures for detecting and preventing fraud, waste and abuse and to attest this to the state by means of a signed affidavit. Thus for many organizations, the adoption of a compliance plan is not discretionary; rather, it is a mandatory condition of receiving payment under federally funded programs.



Protect your organization from costly financial disallowances and extrapolated adjustments

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Stay tuned for the next newsletter which will discuss and analyze some of DSS' final audit reports to providers in 2010.

Contact Jim Wietrak and/or Robert Tobin
To Set Up A Personalized Meeting

COMING SOON: QUESTIONS & ANSWERS

We invite you to submit questions of general interest to you and other providers.

The questions we choose to address will be selected in our sole discretion.



SUBMIT YOUR QUESTIONS AND/OR
COMMENTS TO:

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James Wietrak (Director of Medicaid Audit Services at TCORS)

Prior to joining the firm as a director of Medicaid audit services Mr. Wietrak was the Acting Deputy Commissioner of the Connecticut Department of Social Services. As such he was responsible for the operations of the DSS Bureau of Administration. From 1993- 2009 Mr. Wietrak was the Director of Quality Assurance at DSS, where he directed audits of Medicaid providers and directed recipient and provider fraud prevention and detection activities. He also served as the DSS Project Manager for the department's Data Warehouse and Decision Support System and directed third party liability and asset recovery projects that resulted in recovery and cost avoidance of \$190 million annually. Additionally, he directed quality control reviews of Medicaid, Food Stamps and other federally funded assistance programs. From 1984 – 1993 Mr. Wietrak managed audits of Medicaid providers, fraud prevention and detection activities, and audits of the General Assistance Program.

