TCORS

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SPECIAL POINTS OF INTEREST:

YOU'VE BEEN AUDITED, NOW WHAT?

INTRODUCTION

So you have been subjected to a Department of Social Services' (DSS) audit of your Medicaid billings. What happens now and what do you need to do to protect yourself or your practice from incurring excessive audit disallowances?

First let's summarize the statutory audit process. DSS or its delegate, with some exceptions, must notify the provider that it is being audited at least 30 days prior to conducting an audit. Following the completion of the audit field work DSS will provide a preliminary written audit report not later than 60 days later detailing the results of the audit and the amount of any disallowance.

The provider then has 30 days from receipt of this draft audit report to provide documentation and rebuttal in connection with any adjustments with which the provider disagrees. This is a very important step in the audit process for the provider. It is the provider's first opportunity to present documents and arguments to refute the conclusions in the audit report. It is critical that the provider presents a complete and factual package in response to the audit since this initial response forms the basis for most future arguments and appeals as the audit process works its way to conclusion.

Following the release of the draft report and the provider's 30 day response, DSS will hold an exit conference with the provider for the purpose of discussing the draft report. The provider has another opportunity to present additional evidence refuting findings at the exit conference. DSS will then produce a final written report concerning the audit. This report will be provided to the provider not later than 60 days after the exit conference.

Any provider aggrieved by the decision in the final audit report may request, in writing to the DSS Commissioner, an administrative hearing for the purpose of contesting the results of the final audit report. The written request, which is sometimes referred to as a statement of aggrievement, must detail the items of disagreement that will form the basis of the administrative hearing. A hearing officer appointed by DSS will hear the disputed case. At the hearing, the provider has the opportunity to provide documentation, witnesses, and other evidence to support its disagreements with the audit disallowances as set forth in its written request for a hearing. If the provider disagrees with the final decision by the hearing officer, it can challenge the decision in Superior Court.

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LESSONS FROM RECENT CASE

In a recent court case, Bridgeport Dental, LLC v. Commissioner of Social Services, the Superior Court determined that the DSS review official's conclusions were supported by substantial evidence and that Bridgeport Dental, LLC had not established that DSS acted unreasonably, arbitrarily, illegally, or in abuse of its discretion in its interpretation of applicable law. The court also declined to review two of the plaintiffs' claims because the plaintiff had not raised the claims in its statement of aggrievement to DSS. Bridgeport Dental, LLC then appealed to the Connecticut Appellate Court.

The Appellate Court sided with DSS and the lower court and reaffirmed that a plaintiff who challenges a state agency decision has the "heavy burden of demonstrating that the department's factual conclusion lacks substantial support on the whole record." The plaintiff can only prevail if it meets that burden by including specific documentation of facts and information in its statement of aggrievement. The Court found that the plaintiff met this burden with respect to certain disallowances which therefore warranted adjustments. However, regarding the other disallowances, the Court found that the provider's statement of aggrievement contained mere assertions that the findings of the DSS auditors and hearing officer were erroneous, but did not provide any evidence of factual documentation to substantiate mistakes committed by DSS.

For example, in the Bridgeport Dental case, the Court noted that during the administrative appeal of the final audit report, the DSS hearing officer allowed a charge for x-rays, which the DSS auditors previously denied on grounds that the x-rays were not in the patient's chart. The hearing officer allowed the x-ray charge because, as part of its statement of aggrievement, the provider submitted the actual x-rays for that patient. On the other hand, the Court found the provider's general assertion in its statement of aggrievement that "adequate x-rays had in fact been in [all of the other] patient charts", without submission of the x-rays themselves, was not adequate to reverse the DSS hearing officer's disallowance of x-ray charges for the other patients.

CONCLUSION

This case illustrates that it is important to bring a knowledgeable team including attorneys into the audit process early to help guide you through the process. As noted above, in your initial written response to the draft audit, you need to explain each area of disagreement, why you believe the audit disallowance is incorrect and include the documentation to support your argument. This 30 day document will, in most cases, form the basis of your statement of aggrievement if you request any future appeal and therefore it is imperative that you present it in a way that can be transported to an appeal if one is necessary. In addition, you should document and include in your statement of aggrievement any additional arguments, facts, documents or information, which you presented or discussed at the exit conference held with DSS, if they were not contained in your 30 day response to the draft audit. Be sure that this additional information does not conflict with the arguments and documents you previously presented during the 30 day response period. Since an appeal will most likely be handled by an attorney, having knowledgeable advice and legal oversight during the 30 day response period and exit conference preparation is critical.

The Bridgeport Dental case confirms that providers that are audited by DSS face a fairly rigid process that is based on a set of statutorily established procedures. It is imperative that providers know the process and their rights during each step of the process. Not having this knowledge could result in unnecessary audit disallowances that can add up to tens or hundreds of thousands or in some cases even millions of dollars. TCORS is available to assist providers with navigating through the audit process and has provided this assistance to numerous providers.

About the TCORS Medicaid Group

Our Medicaid Audit Department is comprised of Attorney Robert D. Tobin, partner; Attorney Joseph J. Selinger, partner; James Wietrak, former DSS Director of Quality Assurance; and Denise Smith, Certified Professional Coder and Medical Auditor. They are prepared to conduct Medicaid compliance reviews or "mock audits" of a number of Medicaid providers to identify areas of potential weakness and recommended corrective actions. Both Jim and Denise have extensive knowledge of the requirements governing various types of healthcare providers and continuously keep informed as to the ongoing audits and proposed rules affecting Connecticut's providers.

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TCORS MEDICAID AUDIT SERVICES

- **Educational Seminars**

  We help you understand the DSS Medicaid audit process, and proper billing, coding and documentation procedures.

- **Periodic Record Reviews**

  We replicate an actual Medicaid audit to determine your organization's compliance weaknesses that could save you from costly financial disallowances and extrapolated audit adjustments.

- **Assistance During the Audit Process**

  We assist your organization in developing defenses in response to any draft and/or final audit reports and in negotiating settlements.

- **Appeal Audit Decisions**

  We will represent you throughout the entire appeal process

Contact Us To Set Up A Personalized Meeting

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