Provider Audit Workgroup

August 23, 2016

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning

Agenda

- *Welcome and Introductions*
- *Program Integrity Audit Process*
- *Methodology for Claim Sampling and Payment Analysis*
- *Key Findings from Public Comment Process*
- *Audit Workgroup Group Discussion*
- *Next Steps*

Program Integrity Audit Process

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Indiana Medicaid Program Integrity Audit Process

Program Integrity (PI) conducts retrospective reviews of Indiana Medicaid providers to evaluate and document patterns of healthcare provided to recipients, as well as ensure compliance with Indiana Medicaid guidelines and recover any overpayments. This is facilitated through our Fraud & Abuse Detection System (FADS) contractors.

Steps involved in PI retrospective review process:

1. Preliminary review of provider history – determine next steps
2. Request of medical records from IN Medicaid provider
3. Medical record/on-site audit
4. Draft Audit Findings (DAF) letter of preliminary audit results *
5. Administrative Reconsideration Process
6. Final Calculation of Overpayment (FCO) letter
7. Administrative Appeal
8. Repayment of Overpayment

Program Integrity Audit Process

1. Preliminary review of provider history
   - Identification and analysis of provider enrollment history and claims data to look for possible patterns of aberrant activity
   - Compare provider with peers of like specialty to determine outlier status
   - Review any past audit history to identify previous specific areas of concern
   - Recommendation of proposed action *(including, but not limited to: case closure; medical record audit; prepayment review; payment suspension)*
   - Coordinate and vet recommended action with Indiana Medicaid Fraud Control Unit (MFCU)
   - Initiate recommended action approved by PI

Program Integrity Audit Process
(cont'd)

2. Request of medical records
   - Audit notification letter, via certified mail, is sent to the Mail-To address of provider
   - Claims chosen for review can be identified either on a claim-by-claim basis or as a result of a Statistically-Valid Random Sample
   - Notice of Audit & Request for Records letter details what documentation is requested to facilitate review
   - Providers typically given 30 days to submit the requested documents for review (extensions can be granted when requested in writing by the provider)
   - Requested records submitted in hardcopy or electronically through a secure web portal
   - FADS team will follow up with providers if no response is received
   - ***Typically not first step in audits resulting from an algorithmic review***
     - Algorithmic audit process can begin with dissemination of the Draft Audit Findings (DAF) letter

Program Integrity Audit Process
(cont'd)

3. Medical record/on-site audit
   - Notice of Audit & Request for Records letter will indicate if audit to be on-site or medical record submission
   - Provider staff may remain with FADS team during review
   - Main focus of on-site is to gather requested documents as well as to open communication with provider to ensure a smooth audit process
   - Copies (*not originals*) of requested records reviewed by FADS team at their offices
   - Review of IHCP policies, coding regulations, and all other state/federal rules pertinent to the dates of service audited
   - Preliminary audit results discussed with PI during bi-weekly Analytic and Audit Committee meetings

Program Integrity Audit Process
(cont'd)

4. Draft Audit Findings (DAF) letter of preliminary audit results
   - Preliminary audit results, via certified mail, are submitted to provider
   - Claims cited as possibly aberrant are detailed
   - Violation of specific rules and guidelines included as support of audit finding
   - Letter will indicate if the results are claim-specific or extrapolated, with explanation of extrapolation process if relevant
   - Provider is instructed how to request Administrative Reconsideration of audit findings if they disagree with the preliminary results
   - Provider is required to indicate through the included Provider Intent Form if they agree with the audit findings and wish to receive the Final Calculation of Overpayment, or if they are requesting Administrative Reconsideration

Program Integrity Audit Process
(cont'd)

5. Request for Administrative Reconsideration (RAR)
   - On-going dialogue between provider and PI
   - Provider is able to submit previously omitted documentation, further explanation of internal processes, and anything else to contest the preliminary audit findings
   - Provider must submit new information, records, or arguments when submitting a RAR (*PI unable to reconsider preliminary audit results without*)
   - Upon receipt of new information, audit results will be reconsidered and any reduction of possible overpayments can be facilitated
   - On-going communication takes place between provider and FADS team
   - Upon completion of reconsideration, PI will determine if a Response to Request for Administrative Reconsideration letter is appropriate, or if the Final Calculation of Overpayment should be drafted

Program Integrity Audit Process
(cont'd)

6. Final Calculation of Overpayment (FCO)
   - Determination of overpayment to be returned to IHCP, including (if applicable) extrapolated amount
   - Explanation of program non-compliance resulting in overpayment
   - Claim-specific details, including overpayment and any applicable interest
   - Information included detailing steps for provider to submit administrative appeal
   - Provider notified of Indiana Code requirement to repay overpayment amount within 300 days of FCO
7. Administrative Appeal
   - Appeal must be submitted within 60 calendar days of FCO receipt
   - Include Statement of Issues along with request for Appeal
   - Must detail specific findings, actions or determinations of PI the provider is appealing
   - Include rationale for provider's belief in error of PI determination, as well as statutes & rules supporting providers contentions
   - Appeal is assigned to attorney in FSSA Office of General Counsel and administrative law judge

Program Integrity Audit Process
(cont'd)

8. Repayment of Overpayment
   - Provider is required to repay identified overpayments within 300 days of FCO
   - Failure to make repayment within 300 calendar days will result in recoupment against current claim payment
   - If provider prevails on appeal, FSSA will return the overpayment amount and any interest the provider may have paid, as well as interest to the provider from the date of the provider's repayment
   - Providers can choose to submit payment by check or have overpayment satisfied through accounts receivables against future payments
   - In instances of overpayments due to FSSA system or policy issues, no interest is assessed on identified overpayments.

Methodology for Claim Sampling and Payment Analysis

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Senior Manager, Myers and Stauffer LC

Section Overview

- Statistical Sampling Standards
- Sample Design / Sampling Plan
- Estimating the Audit Mispayment
- Frequently Asked Questions

Statistical Sampling Standards

Myers and Stauffer and their consultant statistician, as a contractor to FSSA PI, adhere to the statistical sampling standards used by the Department of Health and Human Services as embedded in their RAT-STATS statistical software[1].

- Common among statisticians
- Taught in introductory statistics courses at universities world-wide
- No sound alternative to random sampling for claims auditing

[1] https://oig.hhs.gov/compliance/rat-stats/

Statistical Sampling Standards *(cont'd)*

The Department of Health and Human Services methodology, which guides FSSA PI practices, includes five primary steps[2]:

- Selecting the *review period* to be reviewed;
- Defining the *universe*, *sampling unit*, and *sampling frame*;
- Designing the *sampling plan* and selecting the *sample*;
- Reviewing each of the *sampling units* and determining if there was an mispayment;
- *Estimation* of the mispayment.

[2] http://compliance.com/publications/why-rat-stats-and-sampling-are-hot-the-best-strategy-for-health-care-entities-is-one-of-proactive-preparedness/

Statistical Sampling Standards *(cont'd)*

Important Definitions[2]	
Review Period	Period of time over which the population of claims is defined
Universe	All of the claims within a procedure code or set of procedure codes during the review period
Sampling Unit	Item over which the audit is conducted (e.g., claim or claim detail line)
Sampling Frame	List of items that may show up in the sample (e.g., population of claims)

[2] http://compliance.com/publications/why-rat-stats-and-sampling-are-hot-the-best-strategy-for-health-care-entities-is-one-of-proactive-preparedness/

Sample Design / Sampling Plan

Sample Size

- There is no “correct” sample size.
- As the sample size increases, the projection becomes more precise.
  - In statistical terms, larger samples yield smaller margin of error, all else equal.
- The ideal sample size is an effort to balance precision and cost while attempting to minimize disruption to or the time commitment from proivders.
  - The greater the desired level of precision, the larger the sample.

Sample Design / Sampling Plan *(cont'd)*

Sample Size

- Sample size is often determined by establishing a desired level of precision prior to sampling.
- Characteristics of the sample are rarely known prior to conducting the sample.
- As a result, characteristics are often based a preliminary estimate of potential mispayments or other factors when available (e.g., prior audit results).

Sample Design / Sampling Plan *(cont'd)*

Pseudo-Random Number Sampling

- Each claim in the universe has an equal probability of being drawn.
- The sample is drawn using a mathematical algorithm.
- Pseudo-random numbers can be produced by a variety of programs including Microsoft Excel or Microsoft SQL Server.
- To ensure that the random sample can be reproduced, a seed value is employed to generate the random numbers.

Sample Design / Sampling Plan *(cont'd)*

Stratified Random Sampling

- When a provider's claims include more than one procedure code, the population may be stratified by procedure code.
- Stratification aids in ensuring proper representation of high-dollar and/or frequently billed procedure codes.

Estimating the Audit Mispayment

Sample Mean, denoted as $\bar{x}$:

$$\bar{x} = \frac{total\ overpayments}{number\ of\ observations\ in\ the\ sample} = \frac{\sum x}{n}$$

In this expression, x is the value of an overpayment for one of the observations and n is the sample size. The expression $\sum x$ means that all of the overpayments are added together.

Estimating the Audit Mispayment
(cont'd)

Standard Deviation, denoted as s:

$$s = \sqrt{\frac{(x-\bar{x})^2}{n-1}}$$

- The dispersion of the mispayments is measured by the sample standard deviation.
- This number rises as the claims become more dispersed.

Estimating the Audit Mispayment
(cont'd)

Confidence Intervals

- Confidence intervals allow us to make statements about how closely our sample mean lies to the population mean based on knowledge of the normal distribution and the information from the sample.
- FSSA PI utilizes confidence intervals of 95% or 90%.
  - With a confidence interval of 95%, we expect the confidence interval to include the true population mean 95% of the time.
- The sample size is smaller when the 90% confidence interval replaces the 95% confidence interval.

Estimating the Audit Mispayment
(cont'd)

Margin of Error

- The expressions *1.96s/sqrt(n)* and *1.645s/sqrt(n)* are referred to as *margins of error*.
- Sample sizes are often set on the basis of a desired margin of error.
- The sample size rises as the standard deviation of overpayments increases and as the margin of error becomes smaller.

Estimating the Audit Mispayment
(cont'd)

Margin of Error (continued)

Suppose that the desired margin of error is *ME**. Then using the 95% confidence interval, we have

$$ME^* = 1.96\frac{s}{\sqrt{n}}$$

from which it follows that the optimal sample size is

$$n^* = \left(1.96\frac{s}{ME^*}\right)^2.$$

Estimating the Audit Mispayment
(cont'd)

Estimation (Extrapolation) of Mispayment

- Project the sample mean and the confidence interval to the population.
- Estimate the proportion of claims with mispayment.
  - Divide sample mispayment by the number of claims in the sample, then multiply by the number of claims in the universe.
  - Repeat for each stratum, if applicable, and sum all results.

Frequently Asked Questions

- Is it possible that the random sample drawn includes only error claims when all other claims in the universe are non-errors?
- How are underpayments accounted for in the audit/extrapolation process?
- Does CMS allow and utilize random sampling for federal audits?
- Does a change in the error rate from Draft Audit Findings to Final Calculation of Overpayment represent auditor error?

Claim Sampling and Payment Analysis

Quality Control

- We adhere to rigorous quality control procedures.
- We evaluate statistical results as part of the quality control process, which could lead to a recommendation to audit additional claims so as to improve statistical precision.

Audit Disposition

- It's important to note that not all audits result in overpayments. A large portion of them result in provider education or other dispositions.

Key Findings from Public Comment Process

Scott Gartenman, FSSA Deputy General Counsel
Shane Hatchett, OMPP Deputy Medicaid Director
Tatum Miller, OMPP Provider Relations Director

Review of the Process

- Three Public Comment Hearings
  - July 11th – Indianapolis
  - July 13th – Evansville
  - July 18th – Mishawaka

- 62 attendees
  - 14 oral public testimony
  - 4 written comments submitted

Key Findings

From the providers' comments, these four themes emerged. They are represented in their terms and perceptions.

- Look Back Period
- Audit Methodology
- Communication and Transparency
- Provider Education

Look Back Period

- Seven years is too long
- Doesn’t allow providers to modify behaviors in a timely manner
- Punitive in nature
- Technology concerns
- Policy evolution

Audit Methodology

- Extrapolation
  - Validity
  - Random sampling
- Stratification
  - Repayments often exceed reimbursement for the particular code being audited

Audit Methodology *(cont'd)*

- Statistical Relevance
  - Conform with statistical practices
  - Would like generally accepted statistical standards defined and published
  - Follow Medicare and Medicare statistical practices
  - Confidence Intervals appear arbitrary and shift

Audit Methodology *(cont'd)*

- Auditor's experience
  - Should be subject matter experts in relevant field (e.g. dental vs. medical)
- Underpayments
  - Providers are not given credit towards overpayments in instances of underbilling

Communication

- Transparency
- Direct communication with auditors
- Clarity and revisions to provider letters

Provider Education

- Clerical errors
- Utilize the audit process as an opportunity for provider education and not repayments
- Increased education resources and opportunities

Discussion of Findings for Recommendations

- How should the state handle the lookback period?
- What components of the audit methodology can be improved and how?
- What aspects of communication can be improved and how?
- What other ways can provider education be improved?

Next Steps

- OMPP staff to create draft report based on discussion today
- Workgroup will receive electronically in September and provide feedback (also posted online for comment)
- One final meeting in October to make final edits and approve

Adjourn

Questions or comments may be directed to OMPP via e-mail or USPS.

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