INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Provider and Member Utilization Review

LIBRARY REFERENCE NUMBER: PROMOD00014
PUBLISHED: NOVEMBER 21, 2017
POLICIES AND PROCEDURES AS OF SEPTEMBER 1, 2017
VERSION: 2.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of August 1, 2016 Published: February 13, 2017	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of September 1, 2017 Published: November 21, 2017	Scheduled update: • Reorganized and edited text as needed for clarity • Changed Hewlett Packard Enterprise references to DXC Technology • Updated the oversight office for program integrity in the *Program Integrity* section • Added SUR Audit and Overpayment to mailing address in the *Reporting, Returning, and Explaining Overpayments* section • Updated telephone number that providers use to self-report any violation of the federal exclusion policy in the *Federal Exclusion from Program Participation* section • Updated the *Request for Administrative Reconsideration (RAR)* section: – Added FAF letter as an option providers might receive – Added paragraph to clarify what actions providers can take • Combined the *Timely Filing of Claims* section into the *Claim Submission* section and clarified what information appears in the modules referenced in that section • Clarified the instructions in the *Claim Administrative Review and Appeals Procedures* section • Updated PERM review dates in the *Payment Error Rate Measurement Audits* section	FSSA and DXC

Table of Contents

Introduction....1
Program Integrity....2
- Reporting Fraud and Abuse....3
- Surveillance and Utilization Review....3

Provider Responsibilities....3
- Billing IHCP Members....4
- Medical and Financial Record Retention....4
- Reporting, Returning, and Explaining Overpayments....5
- Federal Exclusion from Program Participation....5
- Employee Education About False Claims Recovery....6

Provider Utilization Review....8
- Program Integrity Audit Process....9
- Prepayment Review....14
- Referrals to the Medicaid Fraud Control Unit....20
- Payment Error Rate Measurement Audits....20
- Indiana Recovery Audit Contractor Program....22

Member Utilization Review....23

Provider and Member Utilization Review

Introduction

> *Note: This document describes utilization review and monitoring guidelines for services provided under the fee-for-service delivery system. Review and monitoring guidelines for services provided under the managed care delivery system, other than carved-out services, are handled by the managed care entity (MCE) in which the provider is enrolled. Each MCE may establish and communicate its own criteria. Questions about review and monitoring guidelines for providers enrolled in the managed care delivery system should be directed to the MCE in which the provider is enrolled. The IHCP Quick Reference Guide at indianamedicaid.com includes MCE contact information.*

Utilization review guards against unnecessary medical care and services, and it ensures that payments are appropriate according to the coverage policies established by the Indiana Health Coverage Programs (IHCP). The IHCP accomplishes required utilization review activities through a series of monitoring systems developed to ensure that services are reasonable, medically necessary, and of optimum quality and quantity. Both members and providers are subject to utilization review.

Utilization control procedures safeguard against the following situations:

- Unnecessary care and services
- Inappropriate services or poor quality of service, monitored in accordance with IHCP guidelines
- Inappropriate payments, as defined by the Indiana Family and Social Services Administration (FSSA)

Utilization review activities ensure the efficient and cost-effective administration of the IHCP by monitoring the following areas:

- Billing and coding practices
- Diagnosis-related group (DRG) validations
- Documentation
- Medical necessity
- Misuse and overuse
- Other administrative findings
- Quality of care
- Reasonableness of prior authorization (PA)

The utilization review process assists the FSSA in making important policy decisions. In addition, utilization review activities can identify areas of policy that require clarification or change. It is a valuable tool in shaping policy guidelines to ensure that services are provided in an efficient and effective manner.

Program Integrity

> *Note: The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act with important requirements related to Medicaid program integrity, to help ensure that all aspects of the Medicaid program are strong and functioning well. Under Title VI, Chapter 3, of the DRA, entitled "Eliminating Fraud, Waste and Abuse," the U.S. Congress established the Medicaid Integrity Program (MIP) (Section 6034). Under the MIP, the Centers for Medicare & Medicaid Services (CMS) is statutorily required to develop a five-year, comprehensive Medicaid integrity plan. This plan, along with other information about combating Medicaid fraud, waste, and abuse, is available on the Medicaid Integrity Program – General Information page at cms.gov.*

Title XIX of the *Social Security Act*, *Sections 1902* and *1903*, and regulations found in *Code of Federal Regulations 42 CFR 456* require that the IHCP agency be able to identify and, if warranted, refer cases of suspected abuse or fraud to the Indiana Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation and prosecution.

The Office of Medicaid Policy and Planning oversees a number of program integrity initiatives designed to ensure the integrity of the IHCP through the work of the Program Integrity staff. FSSA Program Integrity exists to ensure that correct payments are made to legitimate providers for appropriate and reasonable services to eligible Medicaid members. Program Integrity's role is to identify potential waste, fraud and abuse and investigate providers identified as potentially abusing services that are reimbursed by the IHCP.

- *Abuse* describes incidents or practices of IHCP providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices can result in unnecessary costs to the IHCP, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. The following is a small list of examples of abuse:
  - Billing and receiving payment from an IHCP member for the difference between the provider charge and the IHCP reimbursement for the service
  - Billing the IHCP at a higher fee than for private-pay patients
  - Submitting claims for services not medically necessary in relation to a member's diagnosis
  - Excessive charges for services or supplies
  - Violation of any of the provisions of the provider agreement
- *Fraud* is an intentional deception or misrepresentation made by an IHCP provider or member that could result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. The following list contains select examples of fraud:
  - Altering a member's medical records to generate fraudulent payments
  - Billing for group visits, such as a provider billing for several members of the same family in one visit, although only one family member was seen or provided medically necessary services
  - Billing for services or supplies that were not rendered or provided
  - Misrepresenting services provided (for example, billing a covered procedure code but providing a noncovered service)
  - Soliciting, offering, or receiving a kickback, bribe, or rebate
  - Submitting claims that have been altered or manipulated to obtain higher reimbursement

Potential fraud and abuse are identified by provider or public complaints received by Program Integrity or through the Surveillance and Utilization Review (SUR) process.

Reporting Fraud and Abuse

Healthcare abuse and fraud affect everyone. The State relies on the healthcare provider community to actively participate in detecting and deterring IHCP abuse and fraud. Any suspected abuse or fraud by IHCP members or providers should be reported to the FSSA Program Integrity staff by mail, telephone, or email:

MS58
Investigations & Coordination
FSSA Program Integrity
402 West Washington Street, E442
Indianapolis, IN 46204

Toll-Free Telephone: 1-800-457-4515
Email: Program.Integrity@fssa.in.gov

When individuals, such as IHCP members or employees of a provider, contact Program Integrity with issues of suspected fraud and abuse, these issues are referred to Investigations & Coordination team for documentation, preliminary investigation, and tracking. Research of claim history is conducted through the IHCP Electronic Data Warehouse (EDW), through MCE databases, or through the work of the Fraud and Abuse Detection System (FADS) team, to determine type and volume of alleged abuse.

Surveillance and Utilization Review

The Fraud and Abuse Detection System (FADS) team reviews claim data at the systems level. The process determines aberrant billing patterns and inappropriate reimbursements that may occur across a specific provider type and specialty. When a potential issue is discovered, thorough research and payment studies are performed to determine if an overpayment occurred. Medical or other records, including x-rays, may be requested from the provider to explain the alleged overpayment. Provider documentation must be sufficient to fully disclose and document the extent of the services provided. See the *Medical and Financial Record Retention* section for details. Overpayments in conflict with IHCP regulations and policies will be recouped from providers.

If the allegations are substantiated by Program Integrity's review, a referral is made to the appropriate entity for further investigation and appropriate action. Program Integrity refers issues to and coordinates efforts with the MFCU, the state of Indiana, the federal government, and county and local law enforcement agencies. The MFCU discerns whether the referrals initiated by Program Integrity rise to the level of a credible allegation of fraud and/or require further investigation for potential criminal or civil prosecution.

All providers and members may be subject to review, fraud referral, and administrative sanctions. Providers and members are notified in writing about the results of any utilization review that has resulted in administrative action. The written notification outlines the administrative action anticipated and includes appeal procedures.

Provider Responsibilities

Program Integrity identifies areas of noncompliance and misunderstanding related to IHCP billing, benefits, and reimbursement. This information is disseminated to the IHCP provider community through IHCP provider publications, such as bulletins and banner pages, as well as provider education presentations. To keep informed of current communications and policy updates, providers must enroll in the IHCP Email Notifications at indianamedicaid.com. Providers that are already enrolled should verify that their email addresses are correct.

IHCP providers are well positioned to help stop abuse of IHCP programs and reverse trends related to misuse and overuse of services and inappropriate billing practices. Providers that rely on billing services and other consultants should carefully monitor how the IHCP is being billed for services. Regardless of who submits the forms, providers are legally responsible for claims filed on their behalf.

Billing IHCP Members

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for an IHCP-covered service. Acceptance of IHCP payment in full is a condition of participation in the IHCP. For more information on charging IHCP members for noncovered services, see the *Provider Enrollment* module.

An IHCP provider can bill a member only when the following conditions have been met:

- The service to be rendered must be determined to be noncovered by the IHCP – for example, the member has exceeded the program limitations for a particular service or PA for the service was denied.
- The member must understand, **before receiving the service**, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service.

If the member has a primary medical provider (PMP) and wishes to receive services from a non-IHCP provider, the PMP must inform the member that services will not be covered and may include an additional out-of-pocket expense.

A generic consent form is not acceptable unless it identifies the specific procedure to be performed and the member signs the consent before receiving the service. If written statements are used, the statements must not contain conditional language such as, "If an IHCP service is not covered…."

Medical and Financial Record Retention

Providers must maintain medical records and other documentation for seven years from the date of service, per *405 IAC 1-5-1(b)* and must openly and fully disclose such records upon request, per *405 IAC 1-5-2*. Failure to provide medical records or other records when requested may constitute an abuse of IHCP policy and a violation of federal law.

Medical records must be of sufficient quality to fully disclose and document the extent of services rendered. This requirement is further addressed in *405 IAC 1-5-1*. A claim form is not considered sufficient documentation. At a minimum, records must include the following information:

- Identification of the individual to whom the service was rendered
- Identification of the provider, or provider's employee and position, rendering the service
- Date of service
- Diagnosis (not required for transportation or dental providers)
- Narrative description of services rendered
- Location of service
- Amount charged for the service

Additional requirements are specified in service-specific *IHCP Provider Reference Modules*, as well as in IHCP provider bulletins and banner pages, the *IAC*, and statutes. In many cases, written evidence of physician involvement and personal patient evaluation that documents the acute medical need is required. Some services, such as therapy, home health, or mental health services, require a plan of treatment and evidence of ongoing evaluation.

Reporting, Returning, and Explaining Overpayments

Under federal law (§Section 6402(d) of the *Patient Protection and Affordable Care Act* (PPACA) of 2010, Pub. L. 111-148, title VI, Mar. 23, 2010, 124 Stat. 753), a provider that identifies an overpayment must report the overpayment and return the entire amount to a Medicaid program within 60 days after the overpayment is identified. See *42 U.S.C. § 1320a-7k(d) – Reporting and returning of overpayments.* A provider that retains an overpayment after the 60-day deadline incurs an obligation under the federal *False Claims Act* and may be subject to criminal and civil liability, including civil monetary penalties, treble damages, and, potentially, exclusion from participation in federal health care programs. A provider that fails to make the repayment within 60 calendar days of identification may also be at risk from a "whistleblower" lawsuit.

In Indiana, overpayments should be returned, reported, and explained to FSSA Program Integrity using the *Voluntary Self-Disclosure of Provider Overpayments Packet* available from the *Program Integrity* page at indianamedicaid.com. Upon completion of the disclosure form, repayment should be returned to the IHCP at the following address:

SUR Audit and Overpayment
FSSA Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297

To avoid overpayments being included in subsequent SUR audits, providers should request claim adjustments as soon as overpayments are identified by internal audit procedures. Adjusting claims or returning overpayments following initiation of a SUR audit does not eliminate audit liability for an error that existed when the SUR team identified the claim for review and notification of an audit was sent to the provider. The net overpayment amount is included in the extrapolation process for audits completed via random sample. See the *Program Integrity Audit Process* section for details.

Federal Exclusion from Program Participation

The Office of Inspector General (OIG) has the authority to exclude from participation in Medicare, Medicaid, and other federal healthcare programs individuals or entities that have been convicted of fraud. If an individual or entity is excluded from participation, this exclusion applies to all state and federal healthcare programs. Any provider excluded by the OIG is not permitted to participate in the IHCP or other federal healthcare programs. The OIG publishes names of excluded individuals and entities. Providers can access the Exclusions Database at oig.hhs.gov.

The following is from the DHHS OIG *Special Advisory Bulletin*, *The Effect of Exclusion from Participation in Federal Health Care Programs (September 1999), C. Exclusion from Federal Health Care Programs*, available at oig.hhs.gov:

> *Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs [including Medicaid]. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner, or supplier that is not excluded.*
>
> *The prohibition against Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries. This prohibition continues to apply to an individual even if he or she changes from one health care profession to another while excluded. In addition, no Federal program payment may be made to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care.*

The following examples of items or services reimbursed by federal healthcare programs violate OIG exclusions when provided by excluded parties. These examples are not a complete list; however, the examples indicate why IHCP providers must screen potential employees and review all current employees for OIG exclusion. These examples are adapted from the DHHS OIG *Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs (September 1999)*:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency, or physician practice, if such services are reimbursed directly or indirectly by a federal healthcare program
- Services performed by excluded pharmacists or other excluded individuals (such as pharmacy technicians) who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any federal healthcare program
- Services performed by excluded ambulance drivers, dispatchers, or other employees involved in providing transportation reimbursed by a federal healthcare program
- Services performed for members by excluded individuals who sell, deliver, or refill orders for medical devices or equipment being reimbursed by a federal healthcare program
- Services performed by excluded social workers who are employed by healthcare entities to provide services to members, and whose services are reimbursed, directly or indirectly, by a federal healthcare program
- Administrative services, including the processing of claims for payment, performed by an excluded individual and reimbursed by a federal healthcare program
- Services performed by an excluded administrator, billing agent, accountant, claim processor, or utilization reviewer that are related to and reimbursed, directly or indirectly, by a federal healthcare program
- Items or services provided to a member by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a federal healthcare program
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of members and reimbursed, directly or indirectly, by a federal healthcare program

Providers are encouraged to check all current and future employees, subcontractors, and agency staff for possible exclusion from participation in federal health programs. Failure to verify this information may result in recoupment, fines, and exclusion from federal health programs, including the IHCP.

Knowing submission of false claims in violation of the exclusion provisions may be prosecuted in state or federal court. Providers must ensure that they maintain and follow written internal procedures for compliance with federal exclusion guidelines. Providers are advised to self-report any violation of the federal exclusion policy to the MFCU by calling 1-800-382-1039.

Employee Education About False Claims Recovery

DRA Section 6032, Employee Education About False Claims Recovery, established *Section 1902(a)(68)* of the *Social Security Act,* which requires certain entities to provide *False Claims Act* education to their employees.

Employer Requirements

Section 1902(a)(68) of the *Social Security Act* reads as follows:

> A State plan for medical assistance must provide that any entity that receives or makes annual payments under the [Medicaid] State plan of at least five million dollars ($5,000,000) as a condition of receiving such payments shall –
>
> (A) establish written policies for all employees of the entity (including management) and of any contractor or agent of the entity, that provide detailed information about
>
> a) the False Claims Act established by sections 3729 through 3733 of Title 31 of the United States Code,
>
> b) administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code,
>
> c) any State laws pertaining to civil or criminal penalties for false claims and statements, and
>
> d) whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f).
>
> (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
>
> (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
>
> An entity is not required to create an employee handbook if one does not already exist. No template of policy language is being furnished to entity as this detail should clearly relate to the entity's specific practices.

Compliance Reviews

DRA Section 6032 further identifies duties of the State to conduct reviews to assess provider compliance. The FSSA or its contractors will conduct reviews annually of selected entities. The reviews include collection and examination of the entities' policies and procedures regarding the education it provides to employees, management, officers, and contractors or agents, as set out in preceding items (A) through (C).

On request by the FSSA or its contractors, entities will provide a copy of the policies and procedures for review purposes. On request by the FSSA or its contractors, entities will provide a copy of the employee handbook, if one exists, for review purposes.

Consequences of Noncompliance

If an entity is found not to be in compliance with any part of the previous requirements regarding the *False Claims Act* and *Section 1902(a)(68)* of the *Social Security Act*, entities are required to submit to the FSSA a corrective action plan within 60 calendar days.

The corrective action plan describes the actions and methods the entity will follow to ensure that the entity comes into compliance. If an entity is required to submit a corrective action plan and does not do so within 60 days, the State may withhold payment to the entity until a corrective action plan is received. The corrective action plan designates a contact person within the entity responsible for communicating details about plan implementation to the FSSA.

Provider Utilization Review

All IHCP providers are subject to ongoing SUR activities. SUR activities identify areas of IHCP misuse, overuse, abusive practice patterns, and potential fraud. Common trends in fraud, waste, and abuse include, but are not limited to, the following situations:

- Billing and receiving payment from a member for IHCP-covered services
- Billing for medically unnecessary services not supported by the diagnoses documented
- Billing for services outside the scope of practice of the enrolled provider specialty
- Billing generic procedure codes when procedure codes specific to the services rendered are available
- Billing IHCP members more than private-pay patients
- Billing inaccurate units of service
- Maintaining inadequate or incomplete documentation to support the services billed
- Noncompliance with published IAC regulations
- Unbundling globally billed charges, such as surgical, laboratory, radiology, and dental services
- Charging IHCP members for missed appointments
- Charging IHCP members for transfer or copies of medical records
- Manipulating service procedure codes for reimbursement

Providers are selected for utilization review based on complaints received by Program Integrity or on the results of the FADS monitoring process, which compares a provider's individual service provision with a peer group of similar specialty. Based on paid-claim information, Program Integrity establishes statistical profiles for provider peer-class groups to monitor the delivery and receipt of medical services. Analyzing and comparing providers with peer groups can identify misuse and aberrant practices. Trained FADS staff completes an analysis of utilization review data.

The objectives for utilization review activities are as follows:

- Assist in identifying and correcting patterns of documentation and billing problems for all IHCP providers.
- Assist the FSSA in developing clear and consistent medical policies.
- Assess quality of care.
- Determine whether services provided and billed are consistent with IHCP guidelines.
- Educate the provider about any problems identified, when appropriate.
- Identify and initiate recovery of overpayment refund amounts due.
- Perform activities that evaluate medical services for appropriateness, reasonableness, and necessity.
- Verify billed services.
- Recover inappropriate IHCP payments.
- Refer credible allegations of fraud to the appropriate investigative entity.

Utilization review of an IHCP provider can result in one or more of the following actions, depending on the review findings:

- Closure of the case because aberrant practices were not confirmed
- Formal request for further documentation from the provider
- Educational contact to correct minor infractions, such as:
  - A letter from the IHCP detailing the inappropriate action
  - A visit by a Provider Relations field consultant
  - A visit by Program Integrity staff to explain program guidelines related to medical necessity and intensity and appropriateness of service, or to assist with administrative aspects of the program
- On-site or in-house audit of medical records (see the *Program Integrity Audit Process* section)
- Recoupment of improper reimbursements due to incorrect billing, insufficient or missing documentation, or lack of medical necessity for services rendered (see the *Recoupment of Overpayment* section)
- Prepayment review of IHCP claims because of serious billing errors that show consistent lack of knowledge of IHCP rules, or lack of desire to abide by those rules (see the *Prepayment Review* section)
- Referral to the FSSA for possible administrative sanctions for continuing noncompliance
- Referral to the MFCU for further investigation and possible criminal or civil prosecution (see the *Referrals to the Medicaid Fraud Control Unit* section)

The main focus of provider utilization reviews, including on-site and in-house medical record audits, is to evaluate utilization and recover overpayments.

Program Integrity Audit Process

Program Integrity conducts retrospective audits of IHCP providers to evaluate and document patterns of healthcare provided to members, as well as to ensure compliance with Indiana Medicaid guidelines, identify instances of underpayments, and recover any overpayments.

Note:	*The purpose and scope of the retrospective audit process does not authorize or allow credit for underpayments. If providers identify underpayments, they may submit claim adjustments as appropriate to obtain additional payment within the current, established, timely filing limit and as mandated by any other applicable law.*

Cases are developed and documented through research and review of the following types of items:

- SUR reports
- Claim samples
- Case files and prior reviews for background information
- Current regulations and laws pertinent to the review, as well as historic regulations and laws in place during the applicable review period
- Medical records
- Referrals

The Program Integrity audit process involves the following steps, explained in detail in the sections that follow:

1. Preliminary review of provider billing, payment, and audit history
2. Request of medical records from provider (if applicable)
3. Medical record or on-site audit
4. *Draft Audit Findings* (DAF) letter of preliminary audit results
5. Request for administrative reconsideration (optional)
6. *Final Calculation of Overpayment* (FCO) letter or *Final Audit Findings* (FAF) letter
7. Administrative appeal process (optional)
8. Recoupment of overpayment (if applicable)

Preliminary Review of Provider Billing, Payment, and Audit History

The preliminary review involves identification and analysis of the provider enrollment history and claim data to look for patterns of possibly aberrant activity. Additionally, Program Integrity looks to compare the provider with peers of like specialty to identify potential outlier activity. A review of any past audit history serves to identify any previous areas of concern identified during another SUR audit. The FADS team then meets to offer a recommendation of proposed action based upon the preliminary review findings. During this time, Program Integrity coordinates and vets recommended action with the MFCU. Finally, the FADS team initiates the recommended action approved by FSSA Program Integrity.

On-site or in-house medical record audits are recommended and performed in the following instances:

- Analysis of the statistical claim data documentation available to the reviewer during the preliminary investigation process does not support the necessity of the services claimed.
- Services appear to be inconsistent with IHCP guidelines.

Request of Medical Records from Provider

A *Notice of Audit & Request for Records* letter is sent, via certified mail, to the *mail-to* address of the provider listed in the IHCP Provider Enrollment system. Claims chosen for review/audit can be identified either on a claim-by-claim basis or as a result of a statistically valid random sample (SVRS) to be extrapolated to the full claims universe selected.

The audit notification letter details specifically what documentation is requested for submission to facilitate the review. Requested records may be submitted in hard copy or electronically through a secure web portal set up by the FADS team. Costs for copies of medical records are not absorbed by the FSSA or any of its contractors.

Providers are typically given 30 days to submit the requested documents for review (extensions can be granted when requested in writing by the provider). The FADS team will follow up with providers if no response to the audit notification letter is received.

Note:	*Audits may be conducted unannounced or with limited notice. A request of medical records is typically not the first step in audits resulting from an algorithmic review of an SVRS. In the case of issues identified by algorithmic review, the audit process can take place without a request for medical records and without an on-site visit, and, instead, the provider is first notified of the audit by the dissemination of the Draft Audit Findings (DAF) letter.*

On-Site or In-House Medical Record Audit

Medical record audits may be conducted at the provider's office (on-site) or remotely (in-house) using copies of medical records that were sent in response to the mailed request.

During the audit process, the SUR team reviews IHCP policies, coding regulations, and all other State and federal rules **pertinent to the dates of service**. The SUR team does not apply current regulation and requirements to historic claims.

The SUR team uses the following criteria when reviewing records:

- The medical record or documentation must support the services billed.
- Services must be covered IHCP benefits.
- Services must be medically reasonable and necessary, as indicated by the documentation in the medical record.
- Services must be billed in the quantities ordered and documented, as indicated by the documentation in the medical record.
- Services must be specifically identified on the provider's itemized statements or the charge tickets maintained by the provider.
- Services must be billed to the IHCP only after other medical insurance resources have been exhausted.
- Services must be billed in accordance with established IHCP policy.
- The physician must order services in writing, as indicated by the documentation in the medical record.

Statistically Valid Random Samples

Provider audits may be conducted using an SVRS of the provider claims or a focused sample, which may be an SVRS, concentrating on one or more specific issues. When the audit is performed on an SVRS of claims, the findings can be extrapolated to the total claim population for recovering overpayments. For example, during an on-site audit, $2,000 was identified as an inappropriate IHCP payment in an SVRS of 100 claims. The total population for the audit time period was 350 claims. To reach the extrapolated overpayment, the actual overpayment is divided by the number of claims in the random sample and then multiplied by the total claims in the population: $2,000/100 × 350 = $7,000.

On-Site Audits

The main focus of the on-site visit is to gather requested documents as well as open communication with the provider to ensure a smooth audit process. Program Integrity staff typically confirms scheduled audits by certified mail subsequent to telephone scheduling; however, audits may be conducted unannounced or with limited notice based on concerns in the identification and development of the case. Providers are typically notified in writing of the results of the audit and any corresponding actions.

To maintain privacy and provider accountability for record security, Program Integrity allows a representative of the provider's office to be present during the on-site audit of the records. However, the following conditions apply:

- Provider office staff can remain with the audit team only to ensure security and physical integrity of the records. Remaining with the audit team is an option for providers, not a requirement.
- Provider office staff can serve as a resource to the audit team by answering questions raised by the audit team or by retrieving missing documentation, when requested.

- Provider office staff will not be involved in the audit process and should not attempt to interfere with the record review process.
- Providers are reminded that audit findings at the point of record review are preliminary and, therefore, no argument or challenges are appropriate.

If a provider's record security procedures would preclude SUR auditors from reviewing original records without provider staff present, the provider may exercise one of the following options when notified of an upcoming SUR audit:

- Appoint a staff member to remain present during the on-site audit of records to ensure the security of original medical records.
- Provide copies of the medical record to be reviewed during the on-site audit, with original medical records being available for SUR audit staff to review as requested.

The provider is not required to exercise any of these options. Providers may continue to allow SUR auditors to review the original medical records. Any copies can be made at the time of the audit. Costs for copies of medical records are not absorbed by the FSSA or any of its contractors.

Draft Audit Findings (DAF) Letter of Preliminary Audit Results

If the Program Integrity staff identifies a possible billing error as the result of an audit, Program Integrity sends the provider, via certified mail, a preliminary DAF letter outlining the claims it believes, based on its audit, may have been billed in error. The specific IHCP, federal, or coding rules and regulations related to the findings are detailed in the letter, as well as whether the audit findings are the result of a claim-specific review or a random-sample audit.

The DAF letter explains that the provider has the option to dispute the draft audit findings by submitting a *Request for Administrative Reconsideration* no later than 45 days after the provider's receipt of the DAF letter. (See *IC 12-15-13-3.5*.) The provider is required to indicate, through completion of the *Provider Intent Form – Reconsideration and Appeal Waiver* (included with the DAF letter), whether they agree with the findings and wish to receive the final calculation of overpayment or to request administrative reconsideration.

Request for Administrative Reconsideration (RAR)

The provider ***must*** request administrative reconsideration before filing an administrative appeal. If a request for administrative reconsideration is not made within 45 days of receipt of the DAF letter, the draft audit findings will not be reconsidered and the provider may forfeit certain rights available to providers under Indiana law. The reconsideration process facilitates a path of open dialogue between the provider and the FADS team.

The provider must submit comments, as well as additional supporting documentation, with the request for administrative reconsideration. If a provider submits a request for reconsideration within 45 days, Program Integrity may reconsider its findings based on any evidence presented by the provider. After the reconsideration process has concluded, Program Integrity sends the provider one of the following letters, detailing the final determination and the provider's appeal rights:

- *Response to Request for Administrative Reconsideration* letter
- *Final Audit Findings* (FAF) letter (when no claim errors are noted in the review)
- *Final Calculation of Overpayment* (FCO) letter

If the provider receives a *Response to Request for Administrative Reconsideration* letter, the provider can either agree to the audit findings or file a second request for administrative reconsideration, as outlined in the letter and second *Provider Intent Form*.

Final Calculation of Overpayment (FCO) Letter or *Final Audit Findings* (FAF) Letter

The FCO letter identifies the amount (including the alleged overpayment and any applicable interest owed on that overpayment) that must be repaid to the state of Indiana. The FCO letter gives explanation of program noncompliance resulting in overpayments, as well as claim-specific details. The FCO letter also explains the provider's right to appeal the finding and the process the provider must follow to maintain and utilize the right to appeal.

If no overpayment is identified as a result of the audit, a *Final Audit Findings* (FAF) letter is drafted to notify the provider of the results and close the audit process.

Administrative Appeal Process

The provider may appeal the findings through the Office of the Secretary of the FSSA within 60 calendar days of the receipt of the FCO letter. A *Statement of Issues* must be filed in addition to the appeal. The *Statement of Issues* must include the following:

- The specific findings, action, or determinations of the IHCP the provider is appealing
- With respect to each finding, action, or determination:
  - Why the provider believes that the IHCP's determination was in error
  - All statutes or rules supporting the provider's contentions of error

The *Statement of Issues* must be filed within 45 calendar days after the provider receives an FCO letter or at the time the provider files a timely appeal, whichever is later, and must comply with all regulations in *405 IAC 1-1.5-2.* A hospital appealing an action described in *IC 4-21.5-3-6(a)(3)* and *IC 4-21.5-3-6(a)(4)* may amend the *Statement of Issues* contained in a petition for review to add one or more additional issues within 30 days after filing a petition for review, and on a finding of good cause by the administrative law judge, per *405 IAC 1-1.5-2(h)*. Per *405 IAC 1-1.5-2(g)*, any provider may supplement or modify its *Statement of Issues* for good cause shown, up to 60 calendar days after filing an appeal. The administrative law judge assigned to hear the appeal determines good cause.

The provider must submit the appeal and *Statement of Issues* documentation to the following address:

MS58
Secretary
SUR Appeals
Indiana Family and Social Services Administration
402 West Washington Street, Room E442
Indianapolis, IN 46204

Recoupment of Overpayment

Incorrect reimbursements are considered overpayments, regardless of how they occurred. Recoupment of excess payments results when the overpayments are identified during the audit process. Excessive payments to a provider that are discovered during any review may necessitate a request for a recoupment.

Overpayments identified during SUR audits are recovered by the authority of *405 IAC 1-1-5*. Such recouped overpayments may be due to one or more of the following:

- Amount paid for such services has been or can be paid from other sources, such as Medicare, private insurance, or a trust fund.
- Overpayment resulted from an inaccurate description of services or an inaccurate usage of procedure codes.

- Overpayment resulted from duplicate billing.
- Overpayment resulted from services or materials determined not medically reasonable or necessary.
- Overpayment resulted from the provider's itemization of services provided to a member rather than billing for a related *group* of services, or global billing, as set out in the IHCP medical policy.
- Overpayment to the provider resulted from any other reason not specified in this subsection.
- Paid claim arose out of any act or practice prohibited by law or by rules of the FSSA.
- Service paid for was provided to a person who was not eligible for the IHCP at the time of the provision of the service.
- Services paid for were not documented by the provider as required by *405 IAC 1-5-1*.
- Services were provided to someone other than the member in whose name the claim was made and paid.

Under *405 IAC 1-1-5*, the amount of overcharges and overpayments may be determined by means of a random or focused sample review. Random sample findings are subject to extrapolation.

Indiana Code IC 12-15-13-3.5(e) requires that providers repay identified overpayments within 300 calendar days of FCO receipt. Failure to make repayment within 300 calendar days will result in initiation of a recoupment process against the provider's current claim payments.

Note:	*Although IC 12-15-13-3.5(e) requires providers to repay the amount of the final calculation within **300 days** of the FCO notification, providers should be advised that, under federal law, a provider that identifies an overpayment must report the overpayment and return the entire amount to a Medicaid program within **60 days** after it is identified. A provider that retains an overpayment after the 60-day deadline incurs an obligation under the federal False Claims Act and may be subject to criminal and civil liability. The FSSA will accept repayments made within 60 calendar days of the provider's receipt of the FCO. For more information, see the Reporting, Returning, and Explaining Overpayments section.*

Providers can choose to have overpayment satisfied through accounts receivable against future payments or to submit payment by check to the following address:

SUR Audit and Overpayment
FSSA Program Integrity
P.O. Box 636297
Cincinnati, OH 45263-6297

If a provider prevails on appeal, the 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. In instances of overpayments due to FSSA system or policy issues, no interest is assessed on identified overpayments.

Prepayment Review

Prepayment Review (PPR) is a SUR provider monitoring program that ensures reimbursement for services is reasonable, medically necessary, and of optimum quality and quantity by reviewing claims and documentation prior to reimbursement. As part of the PPR process, providers are required to send supporting documentation for each claim submission. If the supporting documentation is not submitted, the claim will be denied. The documentation is used to determine the medical necessity of the services rendered and to verify services billed. The option to submit electronic claims is available; however, these claims continue to follow the PPR adjudication process.

The PPR team reviews claims for overutilization of services or other billing practices that, directly or indirectly, result in unnecessary costs to the IHCP. Examples include, but are not limited to:

- Improper payment for services
- Payment for services that fail to meet professionally recognized standards or level of care
- Charges in excess or selection of the incorrect codes for services or supplies
- Billing for services or supplies that should not have been or were not provided based on documentation supplied
- Unit errors, duplicate charges, or redundant charges
- Billing for services for which all required documentation not present with the medical records
- Experimental or investigational items billed
- Items not separately payable, such as routine nursing, capital equipment charges, and so on
- Ensuring the most appropriate and cost- effective supplies were provided
- Ensuring the records and/or documentation substantiate the setting or level of service that was provided to the patient

After the FSSA fiscal agent, DXC Technology, processes submitted claims, the claims are forwarded to the PPR team. Claims are normally processed within 60 days of receipt by PPR, although sometimes, due to administrative actions, claims may take longer than 60 days to adjudicate.

PPR is not a sanction and is not subject to appeal. See *405 IAC 1-1-6(f).*

Note: Crossover claims from Medicare are excluded from PPR.

Policy for Participating in the Prepayment Review Process

PPR will be implemented for a minimum period of six months, unless a provider is terminated from the IHCP within this six-month period for actions outside of PPR.

At the end of the six-month period, if 85% accuracy in claim submission has been achieved for three consecutive months and the provider's claim submission volume has remained consistent with the volume before they were placed on PPR, the provider will be reviewed for release from PPR.

If 85% accuracy in claim submission has not been achieved, the provider will remain on PPR for an additional six months until a compliance review of the provider's claim-billing accuracy ensures that the provider has met the requirements to be removed from PPR.

If, after participating in the PPR process for 12 months, the provider has not achieved 85% billing accuracy for three consecutive months, the provider will continue on PPR and may be subject to sanctions by the FSSA. Sanctions may include:

- Requirement to submit a corrective action plan to the FSSA
- Other sanctions as provided in *405 IAC 1-1-6*
- Termination as a provider (for cause) by the FSSA from the IHCP

Documentation Required for the Prepayment Review Process

Documentation submitted as part of PPR is evaluated to establish whether it supports the following:

- Services were provided according to IHCP policy requirements.
- The billed services were medically necessary, appropriate, and not in excess of the member's need pursuant to physician order, and so forth, as documented in policy or services standards.
- The number of visits and services delivered are logically consistent with the member's characteristics and circumstances, such as type of illness, age, gender, and service location.
- The provider and member were Medicaid-eligible on the date the service was provided.
- Prior authorization was obtained, if required by policy.
- The provider's staff was qualified as required by Medicaid policy.
- The provider possessed the proper license, certification, or other accreditation requirements specific to the provider's scope of practice and IHCP policy at the time the service was provided to the member.
- The claim does not duplicate or conflict with one reviewed previously or currently being reviewed. Continuous submission of the same claim will result in denial and will prevent the provider from being released from prepayment review timely.
- The payment does not exceed any reimbursement rates or limits in the State plan.
- Third-party liability within the requirements of *42 CFR § 433.137* is appropriately billed and accounted for.

Additional documentation may be requested based on provider type.

Claim Submission

During the period of time that a provider is on PPR, claims and documentation should continue to be submitted to DXC, the FSSA fiscal agent, according to existing procedures. All claim submissions must be compliant with all rules and guidelines set forth in the IHCP provider reference modules, bulletins, and banner pages issued by the FSSA; the IAC; and any other applicable rules and regulations. Each claim submission must include documentation to support the reason for billing to the IHCP, as follows:

- Paper claim forms should be submitted by mail to the appropriate address listed in the *IHCP Quick Reference Guide*, along with required documentation, photocopied as single-sided pages.
- For instructions regarding the submission of paper attachments with electronic claims, see the *Claim Submission and Processing* module.
- For instructions regarding uploading attachments to claims submitted via the Provider Healthcare Portal (Portal), see the *Provider Healthcare Portal* module.

The IHCP reminds providers that, for reimbursement consideration, initial fee-for-service (FFS) claims must be filed within one year from the date services are rendered. This policy is compliant with the provisions set forth in *405 IAC 1-1-3*. Claims that do not comply with the one-year timely filing limit will deny for explanation of benefits (EOB) code 512 – *Your claim was filed past the filing time limit without acceptable documentation.*

See the *Claim Submission and Processing* module for exceptions to the timely filing limit, as well as general information about claim filing procedures.

See the *Claim Adjustments* module for information about adjustments (voids and replacements) for paid claims.

Claim Adjudication by Prepayment Review

After DXC completes processing a claim, it is then forwarded, along with the required documentation, to the PPR team for adjudication. Claims are adjudicated on a first-come, first-served basis. The PPR team adjudicates the majority of claims within 60 days of receiving them from DXC; however, some claims may exceed the 60-day time frame because of unforeseen circumstances. This 60-day time frame does not include the 30 days that DXC utilizes to receive and process claims before forwarding them to the PPR team.

Based on the PPR criteria and compliance with IHCP guidelines, a payment determination is made, and the provider is reimbursed or denied payment based on the determination. The provider's organization receives regularly scheduled Remittance Advice (RA) statements, which reflect claim payment or denial, as well as specific reasons for denial, on a claim-by-claim basis.

PPR uses, but is not limited to, the following resources to ensure that reviews are conducted in a fair manner:

- IHCP billing guidelines as stated in the *IHCP Provider Reference Modules*
- National Uniform Billing Guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®[1]) guidelines
- *ICD-10-CM Official Guidelines for Coding and Reporting*, or its successor
- Industry standard utilization management criteria and care guidelines
- National Uniform Billing Committee (NUBC) *Official UB-04 Data Specifications Manual*
- American Hospital Association (AHA) Coding Clinic guidelines
- Chargemaster guidelines as they relate to and define services billed
- Any other generally accepted industry standard guidelines

These resources are widely acknowledged as national guidelines for billing practices and support the concept of uniform billing for all payers. A healthcare provider's order must be present to support all charges, along with documentation to support the diagnosis and services or supplies that were billed. If there is no specific rule related to a charge in question or a participation agreement does not exist, the PPR team will employ these guidelines.

Claim Status – Remittance Advice

For information on the status of submitted claims, a provider should review the Remittance Advice (RA), which can be accessed through the Portal. Additional resources for the RA can be found in the *Financial Transactions and Remittance Advice* module. RAs for submitted claims are posted weekly on Tuesdays.

If providers have further questions about the RA, they can contact Customer Assistance at 1-800-457-4584.

Claim Administrative Review and Appeals Procedures

If a provider disagrees with the IHCP determination of payment, before filing an appeal with FSSA, the provider must first exhaust the administrative review process. Claim reimbursement administrative review procedures are outlined in *405 IAC 1-1-3*. Provider appeals, including claim reimbursement appeals, are conducted in accordance with *405 IAC 1-1.5*.

The same general procedures for claim administrative review and appeals described in the *Claim Administrative Review and Appeals* module apply during the PPR process. The following sections provide an overview.

[1] *CPT copyright 2016 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Claim Administrative Review

Prior to filing a claim administrative review request, the provider must exhaust routine measures to receive claim payment. Routine measures include:

1. Reviewing the RA
2. Making any applicable corrections identified by the adjustment reason codes (ARCs), remark codes, or EOB codes
3. Resubmitting a corrected claim (in the case of a denied claim) or submitting a claim adjustment(void or replacement of a paid claim)

The following steps outline the administrative review process under PPR:

1. Depending on whether the claim was denied or paid, the provider either corrects and resubmits the claim or submits an adjustment to the claim, as follows:
   - On receipt of a claim *denial*, the provider must review the denial, make applicable corrections, and resubmit the claim through the normal PPR claim-processing channels.
   - If the claim was *paid* but the provider disagrees with the reimbursement, the provider must submit an adjustment request with documentation stating why the provider disagrees with the reimbursement.
2. If the provider receives the same results after completing step 1, the provider can file a formal administrative review request using one of the following methods:
   - Submitting a Portal secure correspondence message (using the Administrative Review Request category)
   - Completing an *IHCP Written Inquiry* form (selecting the Administrative Review checkbox)
   - Writing a letter clearly noting "Administrative Review" and stating the reasons for disagreement with the denial or the amount of the reimbursement

   All pertinent documentation must be attached to the request. Administrative review requests submitted by mail must be sent, along with attached documentation, to the following address:

   MS58
   IHCP Provider Claim Administrative Reviews – Prepayment Review
   Indiana Family and Social Services Administration
   402 West Washington Street, E442
   Indianapolis, IN 46204-2739

Note:	*The formal administrative review request must be filed within **15 days** of notification of claim payment or claim denial from the FSSA fiscal agent.*

3. On receipt of the claim administrative review, an FSSA Program Integrity Prepayment Review compliance analyst reviews the request.
4. The analyst investigates the claim and works with other functional areas of FSSA or the FSSA fiscal agent to formulate a detailed response to the provider.
5. If the administrative review confirms that the claim should be paid as the provider requests, appropriate action is taken and the claim is resubmitted for processing and payment.
6. The analyst will respond to all administrative reviews within 90 days of receipt of the request, regardless of the decision to pay or deny the claim. Each denial decision will be specific, detailed, and fully documented.
7. If the administrative review is unfavorable to the provider, the provider then can request an appeal.

Claim Appeals

Prior to filing a request for appeal, the provider must exhaust the formal administrative review process described in the preceding section. The provider must comply with any resubmissions or requests for additional documentation by FSSA or the FSSA fiscal agent, DXC. The provider must have previously received a copy of the administrative review decision. To preserve appeal rights, all the requirements in this section must be followed.

If after the provider has exhausted all the procedures required for an administrative review, the provider still disagrees with the claim determination, the provider can request an appeal. The appeal must be filed within 15 days of receipt of the final administrative review decision. Appeals must be submitted as a Portal secure correspondence message (using the Appeals category) or by mail to the following address:

MS27
IHCP Provider Claim Appeals – Prepayment Review
Office of General Counsel
Indiana Family and Social Services Administration
402 West Washington Street, Room W451
Indianapolis, IN 46204

See *405 IAC 1-1.5* for appeal procedures.

The following is the appeal procedures sequence and the applicable time limits:

- An appeal request must be delivered to and received by the FSSA within 15 days after receipt of the adverse administrative review decision notice on which the appeal is premised.
- An administrative law judge's adverse decision can be appealed by filing objections with the ultimate authority for the FSSA (FSSA Secretary or designee) within 15 days of receipt of the decision by the judge.
- An appellant can then file a petition for judicial review in accordance with *IC 4-21.5-5* if the appellant is not satisfied with the FSSA ultimate authority's review decision.

Six-Month Compliance Review

Six months from the date a provider's PPR claim submission began (unless the provider has been terminated from the IHCP for reasons other than PPR), a compliance review of the accuracy of billing procedures is conducted. On completion of the six-month review:

- If the provider's organization has achieved 85% accuracy in claim submission for three consecutive months and the provider's claim submission volume has remained consistent with the volume before being placed on PPR, the provider will be considered for release from PPR. If inconsistencies in claim submission volume are noted, the provider will remain on PPR.
- If the provider's organization fails to achieve 85% accuracy in claim submission for three consecutive months, continued participation in the PPR process is required with the goal of reaching 85% claim accuracy for three consecutive months within the second six-month time period.

Twelve-Month Compliance Review

As required, another compliance review will be performed after 12 months of PPR. On completion of the 12-month review, the provider is notified of further actions that will be taken, which may include:

- If the provider's organization has achieved 85% accuracy in claim submission for three consecutive months and the provider's claim submission volume has remained consistent with the volume before being placed on PPR, the provider will be considered for release from PPR. If inconsistencies in claim submission volume are noted, the provider will remain on PPR.

- If the provider's organization fails to achieve 85% accuracy in claim submission for three consecutive months, continued participation in the PPR process is required with the goal of reaching 85% claim accuracy for three consecutive months within the third six-month time period.
- If the provider's organization fails to achieve 85% accuracy in claim submission for three consecutive months, the provider's organization may be required to submit a formal corrective action plan to the FSSA with other sanctions as provided in *405 IAC 1-1-6* or be subject to termination (for cause) as a provider from the IHCP.

Release from Prepayment Review

Providers released from PPR may be subject to future follow-up reviews to ensure continued compliance with the IAC; any other applicable rules and regulations; and all rules and guidelines set forth in the *IHCP Provider Reference Modules* and all other IHCP publications, including, but not limited to, bulletins and banner pages.

Communications with Prepayment Review

For any further questions or concerns regarding the PPR process, providers can contact Prepayment.Review@fssa.in.gov or 1-800-457-4515.

Referrals to the Medicaid Fraud Control Unit

Providers identified with a credible allegation of fraud are referred to the Indiana Attorney General's MFCU for investigation. The MFCU is responsible for investigating whether the referrals initiated by Program Integrity require further investigation for potential criminal or civil prosecution. Such an investigation could result in a felony or misdemeanor criminal conviction. Providers under investigation by the MFCU are not identified until court action is filed in a county, state, or federal court. The MFCU can also refer cases of providers convicted of IHCP fraud to the Department of Health and Human Services (DHHS) for civil monetary penalties under the *Federal Civil Monetary Law* of the *Social Security Act*.

Payment Error Rate Measurement Audits

The *Improper Payments Information Act of 2002* (IPIA) requires providers to submit selected medical record documentation to federal contractors during the Federal Fiscal Year (FFY) Payment Error Rate Measurement (PERM) audit cycle.

The IPIA directs federal agencies, in accordance with the Office of Management and Budget (OMB) guidance, to review their programs to determine those that are susceptible to significant erroneous payments and to report the improper payment estimates to Congress. The OMB identified Medicaid and the State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The CMS developed the PERM program to measure the accuracy of Medicaid and SCHIP enrollment, as well as payments for services rendered to recipients. States are reviewed on a rotating three-year schedule that began in FFY 2006. Indiana is participating in the FFY 2017 PERM review (October 1, 2016, through September 30, 2017).

The Medicaid and SCHIP programs are reviewed separately in three areas:

- Fee-for-service claims
- Managed care claims
- Program eligibility

PERM Review Responsibilities

Two federal contractors share responsibilities to conduct a review of the Medicaid and SCHIP fee-for-service claims and managed care claims. Responsibilities are divided in the following manner:

- Statistical contractor (SC) – Responsible for selection of claims sample and conducting the calculation of the claim error rates
- Review contractor (RC) – Responsible for the collection of medical policies and for conducting the medical reviews and claim adjudication reviews

Additional information is provided upon final selection of the contractors involved.

States and providers assist the federal contractors in gathering the data and providing medical record documentation for the review of the claims. If the states disagree with the contractor determinations, the CMS has outlined a process for states to resolve disagreements within prescribed limits.

States conduct the Medicaid and SCHIP program eligibility reviews.

Medical Record Collection Process

The RC conducts reviews of selected Medicaid and SCHIP claims to determine if the claims were paid correctly. If a claim is selected in the sample for a service that the provider rendered to a Medicaid or SCHIP recipient, the RC contacts the provider directly for a copy of the provider's medical records to support the medical review of the claim.

It is important that the provider enrollment information on file with the IHCP be current. Providers can view and update their enrollment information using the Provider Maintenance link in the Provider Healthcare Portal at indianamedicaid.com.

The RC asks providers whether they prefer to receive the request for medical records by facsimile or U.S. mail. After receiving a request for medical records, the provider must submit the information electronically or via hard copy within 75 days. The RC or State staff follows up with the provider at regular intervals to ensure that the requested information is submitted on time. Providers do not receive reimbursement for responding to a PERM request for medical records.

Past studies have shown that the largest cause of errors during the medical review is insufficient documentation. A lack of documentation is an easily preventable error. The FSSA therefore requests that providers submit complete information before the 75-day deadline.

Any documentation requested from providers that is not received by the RC for review is considered an error against a State's Medicaid or SCHIP program. The time line provided will not be extended, and this error cannot be disputed with the RC. If federal financial participation (FFP) is disallowed for a claim, or a portion of the claim, that amount is recovered from the provider by the FSSA Program Integrity staff.

Protected Health Information Concerns

Providers should submit documentation using the methods described by the RC. Understandably, providers are concerned with maintaining the privacy of patient information. Remember that providers are required by *Section 1902 (a) (27)* of the *Social Security Act* to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish the CMS with information, including medical records, regarding any payments claimed by the provider for rendering services. In addition, the collection and review of protected health information (PHI) contained in individual-level medical records for payment review purposes is permissible by the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) and implementing regulations at *45 Code of Federal Regulations, parts 160* and *164*.

Contact Information

The RC provides contact information to providers. Communication with this federal contractor and with the State FSSA PERM contacts is encouraged.

The SUR PERM audit team can be contacted at the following address:

MS58
SUR PERM
FSSA Program Integrity
Surveillance and Utilization Review
402 West Washington Street, Room E442
Indianapolis, IN 46204

Telephone: 1-800-457-4515, option 8
Website: cms.gov/PERM

Indiana Recovery Audit Contractor Program

Section 6411(a) of the *Affordable Care Act* amended section 1902(a) (42) of the *Social Security Act* to require that states and territories establish Medicaid Recovery Audit Contractor (RAC) programs. States that have not received an exemption from the CMS are required by statute to contract with one or more RACs to identify overpayments and underpayments and to recover overpayments from Medicaid providers. The RAC program's mission is to identify and correct improper Medicaid payments through the collection of overpayments and identification of underpayments made on claims for health care services provided to Medicaid beneficiaries. The program enables the CMS to implement actions that will prevent future improper payments in all 50 states. The RAC program serves to compliment the utilization review activities of the Indiana program integrity efforts.

Long-Term Care RAC Audits

The Indiana RAC contractor, HMS, conducts RAC audits of all nursing facilities on a two-year cycle. The audits include a comprehensive review of financial activity for Medicaid-enrolled residents in all IHCP nursing facilities. Each audit covers a three-year review period adjusted by a one-year look-back period from the date when the audit commences. Because claims filed within the most recent 12 months are excluded (due to timely filing allowances), audited claims can date back four years.

The HMS audits focus on, but are not limited to:

- Payments made for dates of service after date of discharge
- Duplicate Medicaid payments
- Appropriateness of reporting Medicare or other third-party payments
- Errors related to patient liability application or collection

Limits Set on Medical Records Requests

The FSSA has set medical record request limits for RAC audits of provider type 01 – *Hospital*. These limits apply exclusively to Medicaid RAC audits of inpatient acute care hospitals only.

The request limits follow these guidelines:

- The maximum limit is set per IHCP Provider ID.
- The RAC may request no more than 300 medical records per individual audit per Provider ID and no more than 600 medical records per calendar year per Provider ID.
- The RAC may not make requests more frequently than every 90 days.
- The FSSA may authorize the RAC to exceed the limit. Affected providers are notified in writing.

Contact Information

For questions about the Medicaid RAC program, contact the HMS RAC audit coordinator at (617) 398-1366. If you have received an audit letter and have questions specific to your audit, contact the person listed in the letter.

Member Utilization Review

Member utilization review identifies members who use IHCP services more extensively than their peers. Members may be selected for utilization review based on their claim history. Reviews can also be initiated due to reports of potential overuse or abuse from various sources, such as providers and other agencies.

Any form of overuse or misuse of services may identify a member for potential inclusion in the Right Choices Program (RCP). The RCP is designed to provide high-intensity member education, care coordination, and utilization management to eligible Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid members identified as overusing or abusing services.

Common reasons for referral to the RCP include the member being treated by several physicians for the same or similar medical condition, purchasing the same or similar medications from several different pharmacies, or frequently using the hospital emergency department for services that are not considered emergencies.

RCP members are assigned to one PMP, one pharmacy, and one hospital. These providers coordinate the member's medical services in a manner that is in the best interest of the member. RCP members can be identified using eligibility verification performed by the Provider Healthcare Portal, Interactive Voice Response (IVR) system, or 270/271 electronic transaction. These mechanisms also identify the names of the IHCP lock-in providers to which the RCP member is assigned. See the *Right Choices Program* module for more information.