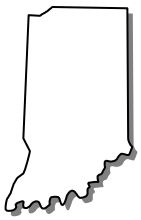
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Home and Community Based Services Waiver Providers

Subject: HCBS Waiver Audit Process, Recoupment, and Appeals

Overview

This bulletin informs all Home and Community Based Services (HCBS) waiver providers of additional information regarding the HCBS waiver audit process, recoupment, and appeals.

EDS is the contracted fiscal agent for the Indiana Family and Social Services Administration (IFSSA) to reimburse services according to the Indiana Health Coverage Programs (IHCP) criteria as outlined in the Indiana Administrative Code *405 IAC 1-5-1*. As part of the federal requirements for oversight of the HCBS waivers, the Office of Medicaid Policy and Planning (OMPP) established an audit process.

Providers were previously notified in IHCP provider bulletin *BT200305*, issued January 15, 2003, that the Division of Disability, Aging and Rehabilitative Services (DDARS) and the OMPP had determined that effective March 1, 2003, claims identified as inappropriately billed to, and reimbursed by, the IHCP that are discovered in the HCBS waiver audits are subject to recoupment.

Audit Process

All agencies and individuals rendering services under the auspices of the HCBS waivers are subject to audit.

Providers may be, but are not required to be, notified prior to the commencement of the review. If notice is given, the initial contact will be made by telephone, followed by a hard copy of the *Audit Notification Letter.* Contained in the letter will be the dates of service subject to review, a listing of all documentation required for the audit and a listing of those members included in the initial audit sample.

> *Note: Additional waiver services, dates of service, and/or waiver members may be added to the audit sample as deemed appropriate by the EDS Audit Team.*

An entrance conference will be held upon the EDS team's arrival at the agency; all waiver staff are welcome to attend. During the entrance conference, the audit procedures will be discussed and a schedule for the audit will be established.

The EDS audit process will include, at a minimum, the following components:

- Examination of the member's approved Plan of Care/Notice of Action (POC/NOA) for the dates of service under review
- Review of all supporting documentation to validate units of service billed to and reimbursed by the IHCP (copies of supporting documentation may be requested by the audit team)
- Review of documentation to support that services were rendered in accordance with the approved POC/NOA, as well as the definitions and parameters of each service and that the services as rendered were not billable to another payor source
- Review of employee records of those individuals who rendered services under review which required specific licensure or credentials
- Home visits to a number of members included in the audit sample to insure that services are meeting the needs of the member and to review the member's eligibility for HCBS waiver services

All HCBS waiver providers must make available to the EDS auditors all necessary documentation and/or other applicable records, in order to fully disclose and document the extent of service billed to the IHCP HCBS waiver program in accordance with *405 IAC 1-5-1*.

The initial dates of service subject to audit will encompass, at a minimum, a twelve-month period and will change on a quarterly schedule (see Table 1 for 2004 examples).

Table 1 – 2004 Examples of Dates of Service

Date of Audit	Dates of Service To Be Reviewed
April, May, June 2004	March 1, 2003 – February 29, 2004
July, August, September 2004	May 1, 2003 – April 30, 2004
October, November, December 2004	August 1, 2003 – July 31, 2004

When the record review and visits are completed, an exit conference will be held to discuss general audit findings. The exit conference also provides an opportunity to share information and for the provision of additional IHCP education; all staff are welcome to attend.

The audit findings letter will be issued to the provider via certified mail within 45 days of the close of the audit.

Recoupment

Overpayments to providers, identified during on-site audits, will be recovered by authority of *405 IAC 1-1-5*. Documentation exceptions as cited in the *Audit Findings Letter* and subject to recoupment include, but are not limited to the following:

- Lack of documentation to support the services and units billed
- Services not authorized on the POC/NOA
- Units billed in excess of those authorized by the POC/NOA
- Services billed when a member was on a leave of absence
- Services billed that are not consistent with the service definition and parameters
- Services billed to the waiver programs that were or could have been reimbursed by a third-party payor (such as Medicare or private insurance) or by Medicaid State Plan services

Table 2 lists exceptions and descriptions.

Table 2 – Authority for Exceptions

Location	Description
405 IAC 1-1-4	Denial of claim payment
405 IAC 1-1-5	Overpayments made to providers; recovery
405 IAC 1-1-6	Sanctions against providers
405 IAC 1-5-1	Medical records; contents and retention
405 IAC 5-2	Definitions
405 IAC 5-4	Provider Enrollment
IC 12-15-13-3	Appeal Procedures
460 IAC 6	Supported Living Services and Supports Rule
BT200305	Changes to the HCBS Waiver Review Process
BT200371	Documentation Standards for HCBS Waiver Programs
IHCP Provider Manual	

The *Audit Findings Letter*, as noted, will be issued to the provider within 45 days of the exit conference. Enclosed with the findings letter will be a copy of *Attachment I* detailing each claim that has been identified for recoupment.

A copy of the *Provider Refund Form* will be included with each letter and attachment. In the event that a provider agrees with the audit findings, and wishes the overpayment to be offset from future payments, the form must be signed and returned to EDS within 60 days.

Should a provider prefer to refund by check, the provider must return a check made payable to the IHCP and mail it to the following address within 60 days:

EDS Waiver Unit
Attention: Waiver Financial Analyst
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288

> *Note: EDS will automatically offset the overpayment amount from future payments if the refund has not been received within 60 days and no notice of appeal has been filed.*

Pursuant to *405 IAC 1-1-5(e*), the Medicaid Office shall recover interest on any overpayment identified. Interest from the date of the overpayment is assessed even if the provider repays the overpayment to the Office within 60 days after receipt of the notice of the overpayment.

The interest charge shall not exceed the percentage set out in *IC 12-15-13-3(f).* Such interest will be applied to the total amount of the overpayment. Interest will accrue from the date of the overpayment to the provider and will apply to the net outstanding overpayment during the period in which such overpayments exists. For purposes of HCBS waiver audits, the date of the overpayment is defined to be the last date of service under review.

If providers disagree with the audit determination, they have the right to appeal under *IC 12-15-13-3*. The appeal proceeding will be conducted pursuant to *405 IAC 1-1.5*. To assert the appeal rights, the provider must file an appeal request within 60 days of their receipt of the *Audit Findings Letter*.

Detailed appeal procedures are listed as follows and are also outlined in the *Audit Findings Letter* and in the *IHCP Provider Manual*.

Appeal Procedures

Note: All appeals must be filed within 60 days of receipt of the Audit Findings Letter.

A provider may elect to appeal the entire overpayment as identified or appeal only specific claims within the overpayment finding. Please note that recoupment activity will be initiated following the 60 days on all identified claims not included in the appeal.

If providers file an appeal request within 60 days, they may elect not to repay the overpayment at this time. If they elect this option, and the Secretary determines after the hearing that the overpayment must be returned to the IHCP, interest will be assessed from the date of the overpayment.

The appeal request is to be mailed to:

Cheryl Sullivan
Secretary, Indiana Family and Social Services Administration
In care of: Pat Casanova, OMPP, LTC Reimbursement, MS07
402 West Washington Street, Room W382
Indianapolis, IN 46204

A copy of the appeal request is to be mailed to:

EDS Waiver Unit
Attention: Waiver Financial Analyst
950 North Meridian St., Suite 1150
Indianapolis, IN 46204-4288

The appeal request must state the following:

- The provider is the party to whom the order is specifically directed
- The provider is adversely affected by the overpayment identified
- The provider is entitled to review under law

If the provider elects to appeal the determination, the provider must also file a *Statement of Issues* **within 60 days** after receiving the audit determination. The *Statement of Issues* will detail the following:

- The specific findings, actions, or determinations of the OMPP or EDS to which the provider is appealing
- Information about why the provider believes that the determination was in error with respect to each finding, action, or determination
- All statutes or rules supporting the provider's contentions of error with respect to each finding, action, or determination according to *405 IAC 1-1.5-2(e)*

The *Statement of Issues* must be sent to the same address as the appeal request, and a copy must also be forwarded to the EDS HCBS Waiver Unit address noted above.

Note: The statement and appeal request may be filed together.

Informal Reconsideration by EDS

In addition to the formal administrative appeal procedures, the OMPP, in conjunction with EDS, offers providers an opportunity to resolve disagreements with overpayment determinations through an informal reconsideration process after the appeal is filed with the OMPP.

This informal reconsideration occurs between the provider and EDS. When the provider has submitted its statement of issues and request for appeal, EDS will conduct an informal reconsideration of the original audit. A reviewer other than the one who performed the original or initial review will complete the informal reconsideration.

Further, for any appealed findings, the provider is strongly encouraged to submit copies of any and all requested records, charts, notes, Individualized Support Plans, account information, billing records, and other documentation as necessary to verify services were provided and appropriately billed to the HCBS waiver programs.

> ***Note: Any documentation <u>not</u> made available for review at the time of the audit will not be accepted as a part of the appeal.***

Upon receipt of the provider's documentation and information, EDS will conduct its informal reconsideration of the appeal documentation and provide a written Response to Statement of Issues. EDS will attempt to notify the provider, within 60 days after the date of receipt of all documentation, of the informal reconsideration findings. The informal reconsideration provides an opportunity to resolve issues among the provider, the OMPP, and EDS. The appeal process is ongoing during this informal reconsideration process; however, this does afford the provider an additional opportunity to resolve the overpayment determination or narrow the issues prior to continuing litigation with the OMPP before an Administrative Law Judge (ALJ).

Summary

All agencies and individuals rendering services under the auspices of the HCBS Medical Model and/or Supported Living and Supports Waivers are subject to audit. Overpayments to providers, identified during on-site audits, will be recovered by authority of *405 IAC 1-1-5*.

Should overpayments be identified during the audit, the provider may elect one of the following options:

- Repay the amount of the overpayment no later than 60 days after receipt of the notice from the OMPP or EDS, including interest from the date of overpayment.
- Request a hearing and repay the amount of the alleged overpayment no later than 60 days after receipt of the notice from the OMPP or EDS.
- Request a hearing no later than 60 days after receipt of the notice from the OMPP or EDS and not pay the alleged overpayment. If the Office of the Secretary determines, after the hearing and subsequent appeal, that the provider owes the money, the provider will pay the amount of the overpayment, including interest from the date of the overpayment.

As previously noted, in addition to the formal administrative appeal procedures, the OMPP, in conjunction with EDS, offers providers an opportunity to resolve disagreements with overpayment determinations through an informal reconsideration process after the appeal is filed with the OMPP.

Table 3 provides an example of the applicable time frames for the required communication of the audit findings and the recoupment and appeals processes.

This example illustrates the dates, actions and time flow for the recovery of overpayments identified during an EDS HCBS Waiver audit. For purposes of illustration, the audit as detailed below concluded on April 1, 2004.

Table 3 – Date, Action, and Time Flow Example

Date	Action	Time Flow
April 1	EDS Completes Audit of Provider Documentation	
May 15	Audit Findings Letter Issued to Provider	
May 18	Audit Findings Letter Received by Provider	Appeal Time Frame Starts
July 17	**Appeal Rights Expire**	**60 Days**
July 18	EDS Initiates Accounts Receivable	61 Days
August 1	EDS Issues Demand Letter to Provider	75 Days
August 8	EDS Initiates Final Collection Phone Call to Provider	82 Days

Direct questions about the HCBS waiver audit process to the EDS Waiver Unit at (317) 488-5343.