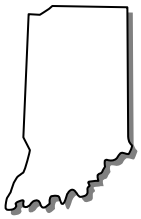

P R O V I D E R B U L L E T I N

B T 2 0 0 9 3 6 N O V E M B E R 1 7 , 2 0 0 9

To: Nursing Facility Providers

Subject: Minimum Data Set Audit Frequency Changes

Overview

The Division of Aging and the Office of Medicaid Policy and Planning (OMPP) are preparing a revision to the current Minimum Data Set (MDS) audit protocol performed under contract with HP. A workgroup consisting of various stakeholders – nursing home providers and consultants, the OMPP, the Division of Aging, Myers and Stauffer, and HP – considered the experience and history of the process since its inception and recommended several changes. Some of the changes will require amendments to the current rules at *405 IAC 14.6* and *405 IAC 1-15*. Until that rule is promulgated, changes will be implemented through Division of Aging's operating protocol. This bulletin outlines changes to be implemented January 1, 2010.

Audit Frequency

The current rule (and audit protocol) requires all facilities to receive a case mix audit every 15 months. The new operating protocol will change the frequency of audits. Some facilities will receive more frequent audits; others will be audited less frequently.

Notwithstanding this rule and audit protocol, paragraphs 23 and 24 of your IHCP Provider Agreement currently allow the state to conduct an audit at any time. Here are the paragraphs:

[Providers agree:]

> 12. To abide by the *Indiana Health Coverage Programs Provider Manual*, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt.
>
> 23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
>
> 24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Indiana Health Coverage Program payments made to Provider, to assure the proper administration of the Indiana Health Coverage Program, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the *Indiana Health Coverage Programs Provider Manual*, and shall include, without being limited to, the following:

> *– a. medical records as specified by* Section 1902(a)(27) of Title XIX *of the* Social Security Act*, and any amendments thereto;*
>
> *– b. records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;*
>
> *– c. any records determined by IFSSA [the Indiana Family and Social Services Administration] or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Health Coverage Program;*
>
> *– d. documentation in each patient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;*
>
> *– e. financial records maintained in the standard, specified form;*
>
> *– f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.*
>
> *– g. any other information regarding payments claimed by the provider for furnishing services to the plan.*

The frequency of audits under the proposed rule and new audit protocol will be determined using the risk criteria below:

Risk Criteria

A *low-risk provider*, defined as having a previous audit score of 90-100 percent, will be audited at a maximum of every three years.

A *medium-risk provider*, defined as having a previous audit score of 80-89.9 percent, will be audited at a maximum of every two years.

A *high-risk provider*, defined as having a previous audit score of 79.9 percent or lower, will be audited every four to twelve months.

The OMPP reserves the right to perform additional MDS audits as deemed necessary at any time.

Effective Date

Rule promulgation will begin soon to incorporate this and other changes into the *Indiana Administrative Code*. However, this piece of the process will begin on January 1, 2010; the frequency of audits on or after January 1, 2010, will be based on the facility's previous audit score. For example: If your audit score in June 2009 was 97 percent, your next audit will be no later than June 2012. If your audit score in June 2009 was 85 percent, your next audit will be no later than June 2011. If your audit score in June 2009 was 65 percent, your next audit could be as early as December 2009 or no later than June 2010. The effective date of other changes will be specified by the rule. If you have questions, please call Karen Filler at (317) 232-4651 or email her at *karen.filler@fssa.in.gov*.