Medicaid Program Integrity for Managed Care Entities (MCEs)

Audits

FISCAL AND OPERATIONS DIVISION
Office of Program Integrity

PRESENTATION

This training is intended to assist Oregon Managed Care Entities (MCE) to responsibly carry out their fraud, waste and abuse prevention, and compliance and oversight obligations under the applicable contract with OHA and federal and state Medicaid laws.

This presentation and the links imbedded in this document were prepared as educational resources; they are not intended to grant or create any rights, privileges, or benefits for you or your organization. No part of this training should be taken as the opinion of, or as legal advice from, any of the Office of Program Integrity (OPI), the Oregon Health Authority (OHA) or the State of Oregon.

Although every reasonable effort has been made to ensure the accuracy of the information within these training materials, the ultimate responsibility for complying with the federal and state fraud and abuse laws and Medicaid program requirements lies with the provider of services.

What we will cover

- Key rules and contract requirements
- Overview of an audit process
- Preparing for audit success
- The audit plan
- Conducting an audit
- Audit documentation
- Audit findings
- Contract deliverables

Rules and contract requirements

Medicaid Managed Care CFR

- When thinking about audits and the accountability of State Medicaid Agencies, MCEs and providers to protect public dollars we start with the Code of Federal Regulations (CFR).
- Several key federal requirements for MCEs for auditing and referring suspected or potential fraud, waste and abuse (FWA) are listed here.

42 CFR § 438.608

- **(a)(1)(vii)** Requires MCEs to establish system with dedicated staff for routine internal monitoring and auditing of compliance risks and promptly respond to compliance issues as they are raised.
- **(a)(2)** Requires MCEs to promptly report all overpayments identified or recovered and requires States to include overpayment retention policies in their MCE contracts.
- **(a)(7)** Requires MCEs to promptly refer any suspected fraud, waste, or abuse to the State.

MCE contracts

- These federal requirements are included in Exhibit B, Part 9, Sections 10 and 11 of MCE contracts.

Exhibit B, Part 9 (10)

- As set forth in additional detail in Sections 11-18 below of this Exhibit B, Part 9, Contractor is responsible for:
  - Developing and implementing a Fraud, Waste, and Abuse (FWA) prevention and detection program and policies and procedures that ensure compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510; and
  - Annually creating a plan for implementing its policies and procedures.

MCE contracts

- Subparagraph (b)(3) requires MCEs to:
  - have a dedicated team of employees; and
  - employ professionals with expertise in program integrity audits.

Exhibit B, Part 9 (11)

- (b)(3) Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and which includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor. Contractor must demonstrate continuous work towards increasing qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees. The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care Providers. The team may employ, or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases;

MCE contracts

- Subparagraph (b)(10) requires MCEs to:
  - Respond promptly to suspected improper or illegal activities of providers or subcontractors.

Exhibit B, Part 9 (11)

- (b)(10) Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees, Participating Providers, or Subcontractors who have violated Fraud, Waste and Abuse policies and procedures and any other Applicable Laws;

MCE contracts

- Subparagraph (b)(15) requires MCEs to:
  - Report any overpayments identified to OHA.

Exhibit B, Part 9 (11)

- (b)(15) Provisions for Contractor to self-report to OHA any Overpayment it received from OHA under this Contract or any other contract, agreement, or MOU entered into by Contractor and OHA. The foregoing reporting provision must include the obligation to report, as required under 42 CFR § 401.305 such Overpayment to OHA within sixty (60) days of its identification;

Exhibit A

- **Overpayment** means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act (42 CFR 438.2)

MCE contracts

- Subparagraph (b)(16) requires MCEs to:
  - Conduct program integrity audits and
  - Report any overpayments identified in those audits to OHA.

Exhibit B, Part 9 (11)

- (b)(16) Provisions for Contractor to conduct Program Integrity (PI) Audits and to report to OHA any Overpayments made to Providers, Subcontractors, or other third parties, regardless of whether such Overpayment was made as a result of the self-reporting or identified by Contractor and regardless of whether such Overpayment was the result of a Fraud, Waste, or Abuse or an accounting or system error.

MCE contracts

- The 2024 contracts clarify use of the term “audit.”

Exhibit A

- **“Program Integrity Audit” and “PI Audit”** each means, but is not limited to, the review of Medicaid claims for suspicious aberrancies to establish evidence that
  - Fraud, waste, or abuse has occurred, is likely to occur, or whether actions of individuals or entities have the potential for resulting in an expenditure of Medicaid funds which is not intended under the provisions of this Contract, State or Federal Medicaid regulations, and
  - Whether improper payment has occurred.

MCE contracts

- Subparagraph (b)(11) requires MCEs to:
  - Refer suspected FWA to OHA.

Exhibit B, Part 9 (11)

- (b)(11) Procedures for reporting Fraud, Waste, and Abuse to the appropriate agencies in accordance with Sec. 17 below of this Ex. B, Part 9

The audit process

Audit process

- In general, an audit process begins with an issue, allegation or data.
- The audit team:
  - Establishes the scope of the audit.
  - Performs the audit.
  - Issues audit findings.
- Providers can review the audit findings, then provide additional documentation.
- A final overpayment is set.
- Providers can appeal the audit findings.
- Overpayment is recovered.

Audit process

1. Issue (from tips or internal sources)

Such as non-compliance, allegations, findings, data anomalies/trends

2. Data Review

Gather information (current data, provider info), run claims/encounters utilization report, and set audit scope.

3. Perform Record Review/Request

Evaluate clinical chart/records to ensure documentation complies with claim submitted, OHP rules, HERC Prioritized List etc.

Check medical necessity and whether in-scope for the provider, etc.

Audit process

4. Overpayment Analysis

Based on the number of non-compliant elements identified the overpayment dollar amount is calculated.

5. Provider Notice/Appeal

Provider, subcontractor or other third party may review audit findings and respond to the audit and the calculated overpayment with additional documents and/or appeal findings

6. Recovery of Overpayment

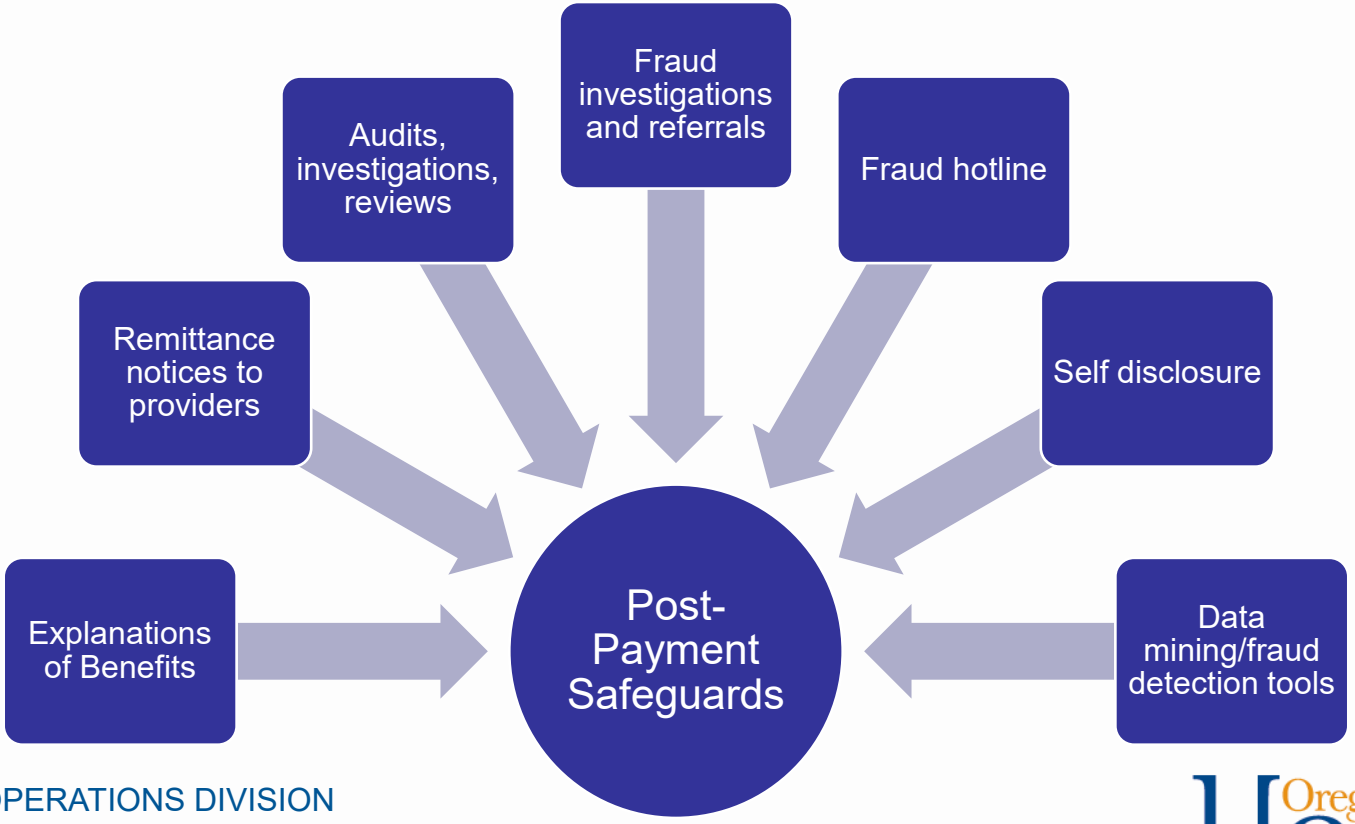
Coordinate with MCE internal staff to seek recovery

Why audit?

- Audits are primarily a post-payment tool. They look back at services already delivered, approved and paid.
- MCEs may also use audits as prepayment safeguards to:
  - Routinely monitor claims.
  - Prevent billing/payment issues.
  - Validate that issues are corrected/resolved.

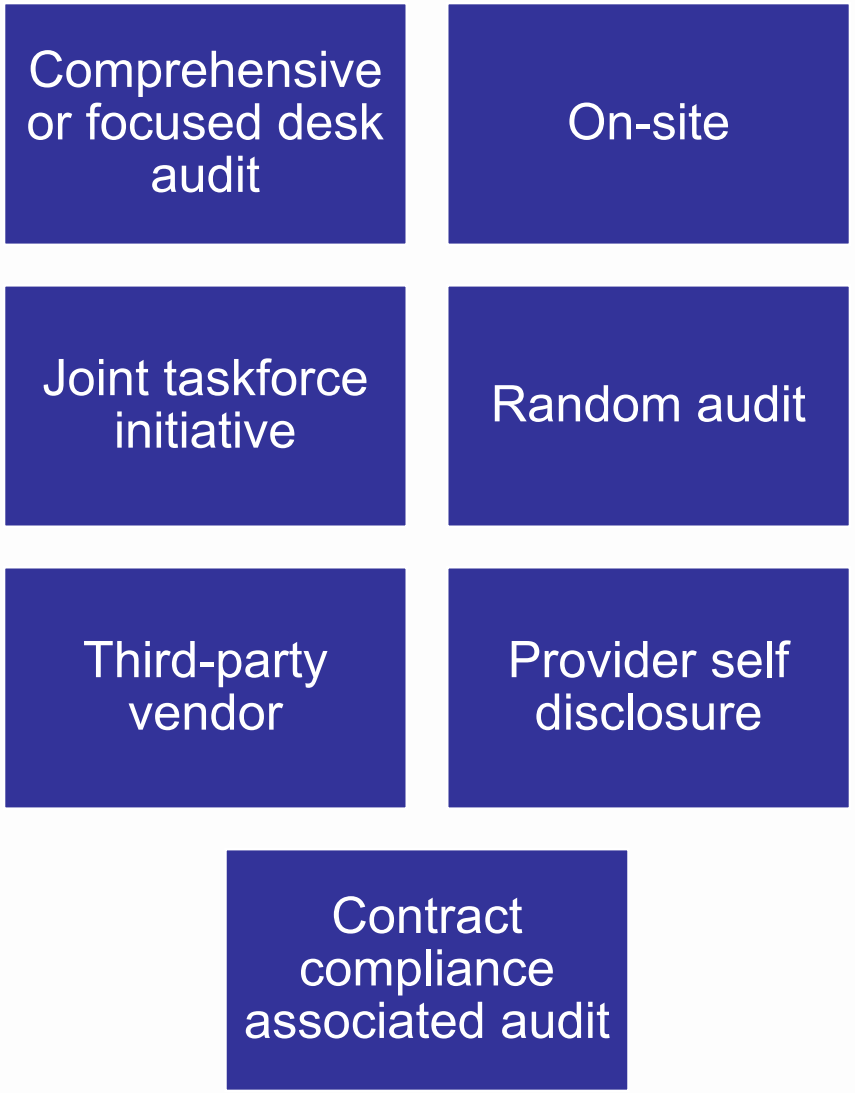
Program Integrity

- Audits are primarily a post-payment tool. Other post-payment safeguards include:



Audit options

- There are many ways and opportunities to audit.
- Your processes for compliance and audits should complement each other.
- You can also use audits to:
  - Take a deeper look at non-compliance or possible FWA uncovered by a compliance review.
  - Reinforce or validate a corrective action plan (CAP).



Audits vs. compliance reviews

- A key difference between audits and compliance reviews is the outcome.
  - Audits look for overpayments. The outcome is a financial finding.
  - Compliance reviews look for compliance with rules and regulations. The outcome is a CAP, contract action or (at times) a contract termination.

Preparing for audit success

Best practices

- You can set your audit team up for success by providing procedures and resources in these areas.
- Consider coordination across teams/units and with subcontractors to:
  - Ensure you do not duplicate work and
  - Make efficient use of resources.

Operating policies and procedures

- Successful auditing starts with pre-planning. This lays a strong foundation for the audit team.
- Documented policies and procedures are an important part of pre-planning.
- Some of the benefits are listed here.

Codify established practices

Maintain consistency between audits

Provide a clear decision-making framework

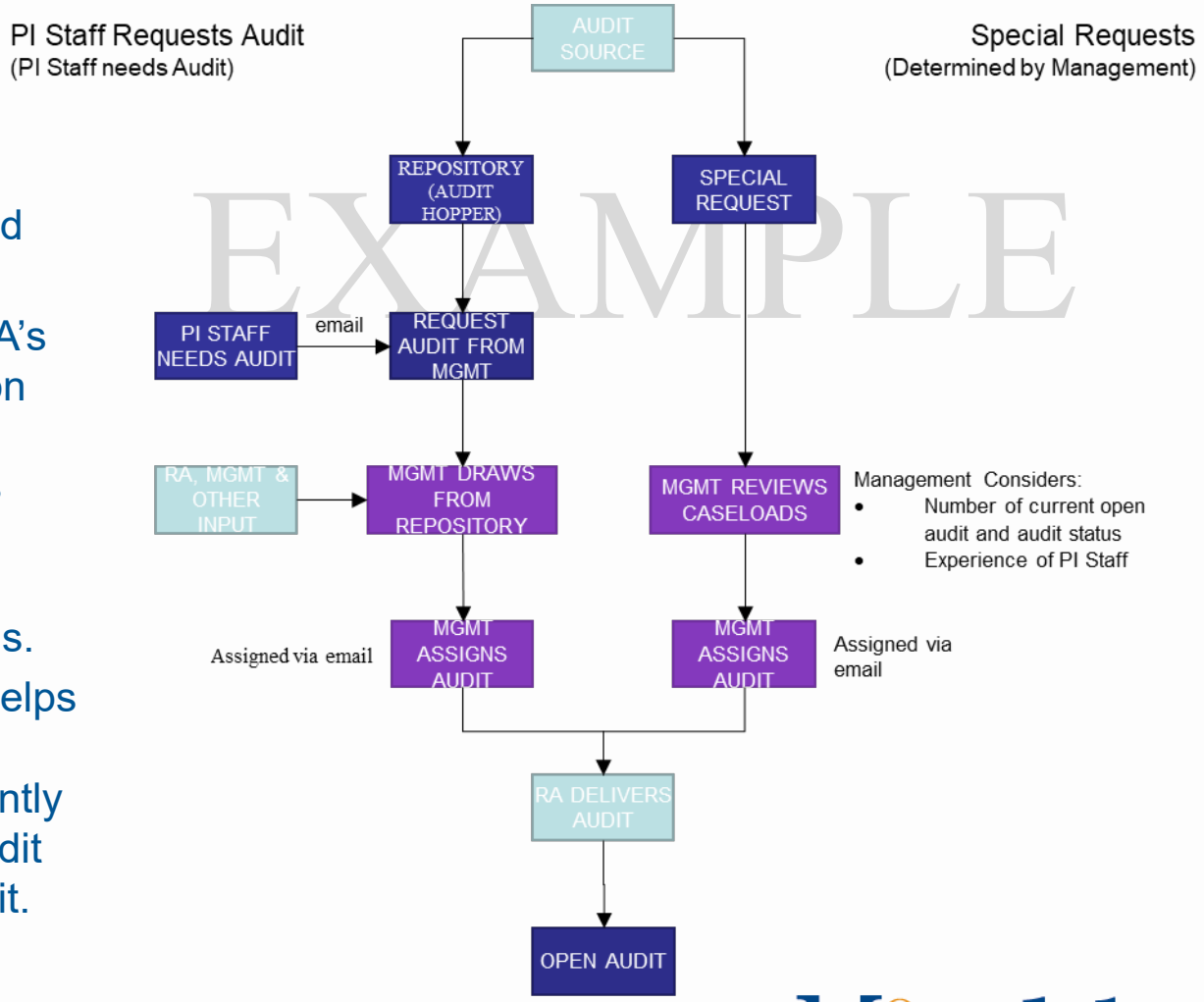
Build the team's confidence about their respective roles in the audit

Help new employees:

- Learn new skills
- Achieve consistent professional standards for auditing

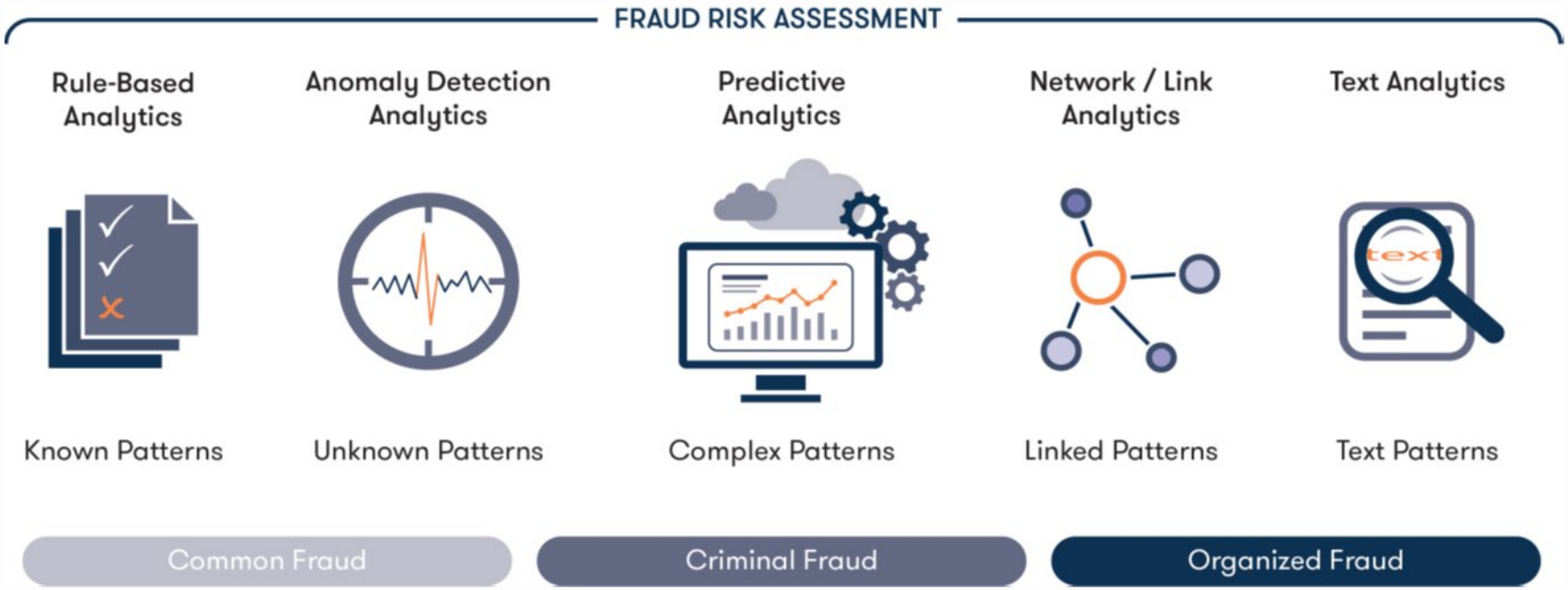
Documenting an audit process

- There are many ways and opportunities to audit.
- This example shows OHA's process for audit selection and vetting. It covers planning, scope, process controls, special considerations, internal controls and data analysis.
- A documented process helps ensure consistency and allows the team to efficiently move through the pre-audit steps to opening the audit.



Using data to inform audits

- Use data to select an audit focus or question.
- Look for patterns, trends and anomalies in the data and information already available to your organization.
- There are many types of analytics that can help detect FWA.



Detecting fraud

- To fight fraud effectively you must:
  - Acknowledge it, and
  - Understand how and why it occurs.
- For fraud to occur, all three elements must be present:

Data analytics

- Routine monitoring/oversight processes can:
  - Help you detect fraud, and
  - Inform your audit plans.
- When a pattern is detected by routine monitoring/oversight processes, then you can plan an audit based on what you have detected in the surveillance phase.
- Selecting an audit focus or question starts with looking at the data and information already available to your MCE.

Data analytics

- Data analytics that identify suspicious transactions or behaviors are the most effective antifraud control you can put in place.
  - In 2018, the Association of Certified Fraud Examiners found that this reduced the cost of fraud schemes by 52 percent and reduced the duration by 58 percent.
- It doesn't have to be costly or complex. It can be low-cost and open source.
- If this is too much to do in-house, you can hire/contract or sign up for third party independent solutions.

Opening an audit

Organize your approach

- These best practices for a successful audit will help ensure that correct payments are made to legitimate providers and suppliers for appropriate and reasonable services and supplies for eligible beneficiaries.

Prepare for litigation from the beginning

- Excellent recordkeeping
- Consistently applied rules
- Documented policies and procedures

Know your audit candidate

- Who is your provider?
- How many providers share this location?
- Does the provider have more than one location?
- Is the provider still at this location?

Focus the audit

- Identify the targeted compliance issues or areas of higher risk
- Consider the most efficient use of your time and your team

Have a written audit plan

Audits in action: opening an audit

- Let's discuss audit planning and process steps in the context of a MCE audit of a provider.

- Provider audit example:
  - The MCE has received this tip.
  - Given the information available, the MCE decides that a focused desk review of the dental provider is the best audit option.

Tip received

- A dental code was potentially billed incorrectly.
  - May not be supported by the documentation and/or
  - Key documentation was missing.
- Tip received was for 2018.

Other information

- Dr. S. has been a MCE participating dental provider since 2016.
- Dr. S. sees on average 250 MCE members annually.

The audit plan

- Once you have selected an audit option, draft an audit plan. The plan should:
  - Be specific to the individual audit you are planning.
  - Include these key elements.

What does an audit plan look like?

Introduction
- Who are you?
- What is the background?

Methodology
- How will you perform this audit?
- Includes planning, pre-engagement reviews, engagement, schedule

Engagement Steps
- Notifications
- Conference
- Engagement
- Preliminary findings
- Final findings

Standards
- Will any set standards or measures be used?

Scope and Objectives
- Who are you engaging?
- Why are you engaging them?
- How will you review to meet your goal?

Staffing for audit success

- Have gathered the employees you need for your audit plan to be successful?
- Part of planning for audit success is ensuring you have the right resources available.
- You may need different types of expertise depending on the focus, scope and methodology of the audit.

Billing

- Certified Professional Coders

Medical appropriateness

- Clinical experts
- Registered nurse

Auditing

- Financial auditor
- Medical auditor
- Medical reviewer

Data mining and sampling

- Research analyst
- Statistician

Program and policy experts

Staffing for audit success

- Audit team members must:
  - Be familiar with the law, rules and regulations relating to Medicaid.
  - Be familiar with the law, rules and regulation relating to the specific services being audited.
  - Know the codes under review.
  - Be familiar with the billing mechanism.

Data, data, data

- Data is an essential element for every audit.
- Most organizations have systems in place to run reports and allow teams to identify trends, patterns and outliers in the data.
- On the next slide are examples of some common but useful reports to run: Encounters/claims, utilization environment, and peer comparison.
- This list is limited only by your imagination!

Data, data, data

Encounters/Claims used for data mining

- SURS Reports, Ranking Reports
- Matching encounters/claims to Member or Provider data
- Simple algorithms for matching other claims for duplication or near duplicates
- Total billings or ordered services by provider
- Calculate the number of members seen in a day
- Surge reports
- Policy violations
- Ensure edits are working or if new ones needed

Data, data, data

Example Algorithms

- Time Bandit: Improbable # of hours in a day
- Mutually exclusive procedures
- Excessive or duplicative benefits
- Excessive use of diagnostics
- Inappropriate drugs and over-use of narcotics
- Vague diagnosis with high-cost procedures
- Consider other payors, region/geography (rural/frontier/urban)

Peer Comparison: providers who are extreme outliers when compared with peers

- Average Medicaid payment per member served
- Average number of services provided per member per visit
- Average number of services provided per day
- Proportion of members who received a specific service (e.g. fillings, extractions, stainless still crowns)

Peer Comparison: specialty provider to specialty provider

- Average Medicaid payments per child served
- Average number of services provided per day
- Average number of services provided per child per visit
- Consider other payors

Audits in action: Focus and scope

- In our example audit, the MCE has chosen a timeframe that accounts for:
  - how long it may take for dental claims for service dates in 2018 to fully complete the adjudication process.
  - final amounts for services paid to the provider.
- MCE pulls a statistically valid sample* of claims submitted during this period.

Audit focus:

- Excessive or duplicative benefits

Audit scope:

- Claims/encounters billed during lookback period:
  - June 1, 2017, through Aug. 31, 2019

*Learn more in OIG's guide to statistical sampling.

Audits and referrals

- MCEs often ask when to make referrals during their audit process.
- The answer is any time that:
  - You suspect possible FWA or
  - You find an issue with one or more of the FWA characteristics listed in Exhibit B, Part 9, Section 16.
- The timeline for referral is within 7 days of discovery.

When should MCEs make a referral to the state/MFCU?

- Promptly but in no event more than seven (7) days after becoming aware of the suspicious case.

What should be reported?

- All suspected cases of FWA, including suspected Fraud committed by employees, Participating Providers, Subcontractors, Members, or any other third parties.
- Regardless of MCE's suspicions or lack thereof, incidents with any of the characteristics listed in Section 16 of Exhibit B, Part 9.

The audit

Audits in action: Implementing the audit plan

Introduction
- Who are you?
- What is the background?

Methodology
- How will you perform this audit?
- Includes planning, pre-engagement reviews, engagement, schedule

Engagement Steps
- Notifications
- Conference
- Engagement
- Preliminary findings
- Final findings

Standards
- Will any set standards or measures be used?

Scope and Objectives
- Who are you engaging?
- Why are you engaging them?
- How will you review to meet your goal?

Audits in action: Staffing for audit success

- Has the MCE gathered the employees needed for the audit of Dr. S. to be successful?
- Based on the focus of the example audit, the key types of expertise the MCE needs are:

Billing

- Certified Professional Coders
- Dental billing experts

Medical/Dental appropriateness

- Clinical experts in dental services
- Dental standards of practice

Auditor

Data mining and sampling

- Research analyst/Statistician who can pull reports from your data and pull encounters out of your record system

Program and policy experts

- Medicaid dental policy experts
- Contract and dental rules knowledge

Tips for maximizing time/efficiency

- If other issues arise during the audit, you may want to investigate those issues. But first, stay focused on completing the audit as originally planned.
  - Know time constraints.
  - Stay focused on audit objectives.
  - Remain flexible, but do not get distracted by new ideas.
- As mentioned earlier, collaborate with other units or departments to get information that is already available.

Tips for provider communication

- In general, an audit should not be a surprise to the provider.
- Be transparent and establish communication upfront.
- Your audit will be more effective if providers cooperate.
- Here is what you should include in your written or verbal communication.

Audit objective and methodology

Sampling and extrapolation, if it applies

Audit scope

Preparing for provider interviews

- An interview is not required for all audits.
- Typically, the interview is your one opportunity to engage the provider.
- To make sure it's successful, prepare by doing these things before you have the interview.

Ask:

- What is the purpose of the interview?

Know:

- The legal components of FWA
- Your MCE's payment rules, contracts, and state regulations
- Your facts

Prepare questions:

- Use both open-ended and closed questions.
  - Open-ended questions allow for an explanation.
  - Closed questions require only "Yes" or "No" answers.

Tips for provider interviews

- Always be polite, non-accusatory and factual.
- Ask questions that lead to a conclusion.
  - Example: ask Dr. S. to explain the process of coding a dental office visit.
- Listen for key components and justification.
- Watch for verbal and nonverbal indicators, such as potential signs of stress:
  - Justifications
  - Defensive tactics
  - Overelaborating/explaining when a “Yes” or “No” will do
  - Refusing to explain a process or procedure

Audit documentation

- Audits generate a lot of documents. The specific documents for your audit will depend on:
  - The audit's scope and
  - Your relationship with the subject(s) of your audit.
- But generally, audit documents fall into these categories.

Provider communication

- Notice of Intent to Audit
- Opening conference
- Request for records

Auditor work papers and reports

- Copies of federal and/or state policies and regulations
- Copies of medical/financial records to support the finding
- Copies of state generated remittance advices which support the claim payment or credit adjustment
- Correspondence, such as Provider Notification Letters and Record Request Letters/Lists;
- Investigator's notes regarding the investigation; and
- Miscellaneous memoranda that pertain to the investigation.

Documentation of MCE actions

- Overpayment amounts
- Referrals

Internal processes

- Memos
- Audit plan and key decisions

Why document?

- Adequate audit documentation:
  - Preserves the facts and your findings.
  - Prepares for possible litigation.
  - Supports initiating investigations or follow-up audits.
  - Shows where MCE changes may be needed:
    - Policy
    - Operations
    - Contracts (subcontracts or provider agreements)

Audit documentation best practices

Data Analysis

- Save all queries.
  - You must be able to replicate any results.
  - A defense expert will want to replicate them, too.
- Preserve the raw data.
- Articulate any changes you made to copies of working data.

Data Mining

- Document what your universe was and what you "mined."
- Keep the universe.

Working File

- Contains evidence accumulated throughout the investigation to support:
  - The work performed,
  - The results of the investigation, including adjustments made, and
  - All assumptions made by the reviewer.

Medical records review

- Request and review medical records against the claim to:
  - Determine whether the documentation truly supports the submitted claim.
  - Auditor should look for:

Possible falsification or alteration of records

- Including, but not limited to:
  - Obliterated sections
  - Missing or inserted pages
  - Use of correction tape/fluid
  - Excessive late entries (i.e., information documented many days after the service was performed)

Evidence that the service billed for was provided as billed

- Untampered, supporting documentation
- Records and dates of service support the claim

Patterns and trends that may indicate potential FWA

- For example:
  - No records available for the billed service
  - Medical record shows different services provided than billed
  - Length of time listed in the medical record is less than time billed

Claims and coding

- Records and documentation in an audit will include medical coding.
- Coding is important because:
  - All health care claims are billed using codes.
  - Codes give us a common language.
- We can use codes to:
  - Process claims and control reimbursement.
  - Consistently report and track services, procedures and supplies provided or billed.
- Codes are updated annually and the rules for medical codes can change due to these updates.

Types of codes

ICD-10-CM

- International Classification of Diseases, 10th Revision, Clinical Modification
- Diagnosis codes (signs & symptoms, diseases, injuries, status and history)
- Maintained by the National Center for Health Statistics

HCPCS

- Healthcare Common Procedure Coding System
- Maintained by the Centers for Medicare & Medicaid Services (CMS)
- Includes AMA's Current Procedural Terminology
- Uses modifiers to indicate that a service/procedure is altered, but not changed in definition

CDT

- Current Dental Terminology
- Dental supplies and procedures
- Published by American Dental Association

NDC

- National Drug Codes
- Manufacturers report to FDA the NDCs for all drugs produced or sold in the United States

Audits in action: claims and coding

- In the example audit, the MCE auditor will:
  - Request medical records/chart from the dental provider, Dr S.
  - Review the records and compare with the dental codes on the claim billed for each service.
- An example of this type of review is on the following slide.
- The CDT codes reviewed for this audit are in the table, 4th column from the left:
  - D4341 Periodontal Scaling & Root
  - D4342 Periodontal Scaling 1-3 teeth
  - D4910 Periodontal Maint Procedures
  - D2392 Post 2 Srfc Resin based Cmpst
  - D7140 Extraction Erupted Tooth/Exr
  - D2393 Post 3 Srfc Resin based Cmpst

Audits in action: claim review

Sample	Recipient Name/ Recipient ID	Date of Service	Procedure Description/ Procedure Code	ooth #	Tooth Surf.	Tooth Surf.	Tooth Surf.	Preliminary Audit Findings	Paid Amount	Correct Amount	Over Payment Amount
1	John Doe	2/13/2019	Periodontal Scaling & Root D4341	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4341 in violation of OAR 410-123-1260 (7)(b)(A)(iii).	$63.17	$0.00	$63.17
2	Jane Doe	4/13/2019	Periodontal Scaling 1-3teeth D4342	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4342 in violation of OAR 410-123-1260 (7)(b)(A)(iii).	$47.37	$0.00	$47.37
3	John Smith	9/5/2017	Periodontal Maint Procedures D4910	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4910 in violation of OAR 410-123-1260 (7)(c)(A)(d).	$32.75	$0.00	$32.75
4	Jane Smith	12/1/2017	Post 2 Srfc Resin based Cmpst D2392	14	D	O		No Financial Finding	$46.60	$46.60	$0.00
5	Judy Doe	11/8/2018	Extraction Erupted Tooth/Exr D7140	12	#	#		No Financial Finding	$99.58	$99.58	$0.00
6	Jane Smith	11/15/201	Post 3 Srfc Resin based Cmpst D2393	15	M	O	D	Potential Financial Finding: •Restoration performed on tooth exceeds frequency limitation for plan in violation of OAR 410-123-1260 (5)(a)(C).	$118.81	$0.00	$118.81

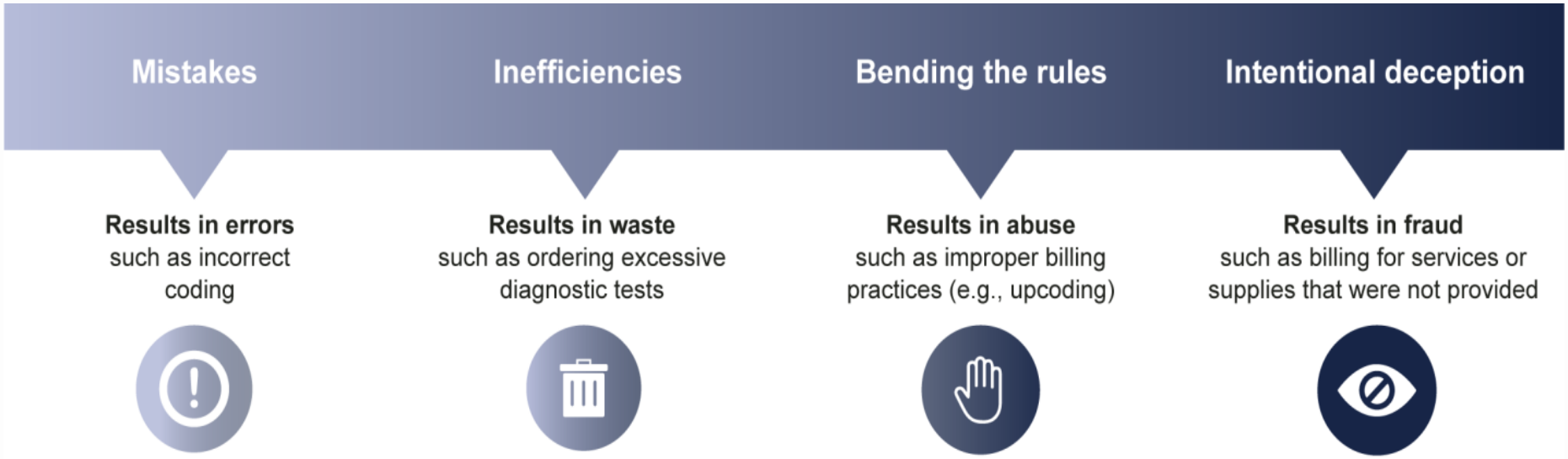
Audit findings

Provider communication

- Present findings to the provider when possible.
  - Audits focused on waste and inefficient practices can often be discussed with the provider during, or at the close of, the audit.
  - Interviews with the provider are valuable and may be necessary at the close of an audit for successful resolution, correction or prevention of issues identified during the audit.
- Audits where fraud or abuse is suspected require a tighter timeline.
  - Get to the key players for interviews sooner rather than later.

Audit findings are not always fraud

- Findings consider the full spectrum of program integrity. Mistakes, through to intentional deception.



Definition of “fraud”

- Fraud is intentionally submitting false information to the government or a government contractor to get money or a benefit.

42 CFR § 455.2

- **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

Definition of “abuse”

- Abuse must result in an unnecessary cost to the Medicaid program. It includes:
  - Actions that may result in unnecessary costs to the Medicare program.
  - Paying for items or services that shouldn’t be covered, but not because the provider was fraudulent (misrepresented facts to obtain payment).

42 CFR § 455.2

- **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Definition of “waste”

- “Waste” defines practices that are inefficient or otherwise cause unnecessary cost to the Medicaid program, such as:
  - Overusing services.
  - Misusing resources.

Exhibit A, MCE Contract

- Over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.

Definition of “overpayment”

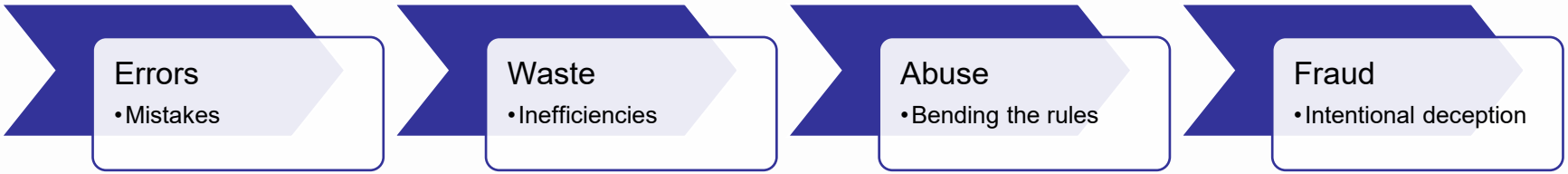
- Also known as “improper payments,” overpayments are payments that should not have been paid.
- Not all improper payments are fraud, but all payments made due to fraud schemes are improper.

42 CFR § 438.2:

- means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a State to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

Causes of improper payments

- CMS and OHA investigate all causes of improper payments, from honest mistakes to intentional deception.
- The vast majority of improper payments is due to unintentional errors:
  - Someone is billed or paid too high/low due to a data entry error.
  - The most common error is insufficient documentation.



Documentation of medical necessity

To document medically necessary care, dental providers need to document not only the extent of services, but also the medical necessity of those services.

- This means documenting both the diagnosis and the treatment.
- Good documentation can answer common questions about treatments billed to Medicaid.

Dentally necessary care:

- Consistent with generally accepted standards of practice
- Reasonably necessary to prevent significant illness or disability or to alleviate severe pain
- The least costly course of treatment that adequately addresses the problem

For documentation of dental necessity to be adequate, the chart and treatment notes should include:

- The diagnosis.
- A description of the conditions requiring treatment (the specific conditions making treatment necessary). Document the disease on the tooth chart, surface by surface, as determined by visual or tactile clinical examination or by X-ray.
- References to the supporting diagnostic tests, laboratory reports, etc.

Audits in action: findings

- In our example audit, the MCE identified these issues after examining the claims and associated dental chart notes.
- These are the audit findings.

Documentation did not support the code(s) billed

- Sample 1 – periodontal charting; millimeter periodontal probing depths did not meet OAR requirements (≥5mm)
- Sample 3 – patient history; the dental chart notes did not include a history of periodontal therapy. OAR requires history of periodontal therapy within the past 3 years

The frequency limitation has been exceeded for the code billed

- Sample 6 – exceeds service frequency; the OARs limit payment for posterior composites (restorative services) to once every 5 years

Audits in action: findings

- Samples 1, 2, 3 and 6 – findings.
- Samples 4 and 5 – no findings.

Sample	Recipient Name/ Recipient ID	Date of Service	Procedure Description/ Procedure Code	Tooth #	Tooth Surf.	Tooth Surf.	Tooth Surf.	Preliminary Audit Findings	Paid Amount	Correct Amount	Over Payment Amount
1	John Doe	2/13/2019	Periodontal Scaling & Root D4341	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4341 in violation of OAR 410-123-1260 (7)(b)(A)(iii).	$63.17	$0.00	$63.17
2	Jane Doe	4/13/2019	Periodontal Scaling 1-3teeth D4342	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4342 in violation of OAR 410-123-1260 (7)(b)(A)(iii).	$47.37	$0.00	$47.37
3	John Smith	9/5/2017	Periodontal Maint Procedures D4910	##	#	#		Potential Financial Finding: •Documentation does not support billing of CDT code D4910 in violation of OAR 410-123-1260 (7)(c)(A)(d).	$32.75	$0.00	$32.75
4	Jane Smith	12/1/2017	Post 2 Srfc Resin based Cmpst D2392	14	D	O		No Financial Finding	$46.60	$46.60	$0.00
5	Judy Doe	11/8/2018	Extraction Erupted Tooth/Exr	12	#	#		No Financial Finding	$99.58	$99.58	$0.00
6	Jane Smith	11/15/2018	Post 3 Srfc Resin based Cmpst D2393	15	M	O	D	Potential Financial Finding: •Restoration performed on tooth exceeds frequency limitation for plan in violation of OAR 410-123-1260 (5)(a)(C).	$118.81	$0.00	$118.81

Audits and referrals

- A referral can and must be made at any point in the audit process – planning phase through recovery of an overpayment.

When should MCEs make a referral to the state/MFCU?

- Promptly but in no event more than seven (7) days after becoming aware of the suspicious case.

What should be reported?

- All suspected cases of FWA, including suspected Fraud committed by employees, Participating Providers, Subcontractors, Members, or any other third parties.
- Regardless of MCE's suspicions or lack thereof, incidents with any of the characteristics listed in Section 16 of Exhibit B, Part 9.

Calculating overpayments

- How the MCE calculates an overpayment depends on:
  - The type of audit
  - The sampling used in the audit
  - The MCE's payment agreement with the provider
    - Capitated or case-rate – can construct a formula to calculate
- All overpayments must be calculated using a reasonable and consistent methodology

Calculating overpayments

Actual overpayment

- For those claims reviewed, the sum of payments (based on the amount paid to the provider/supplier and Medicaid approved amounts) made to a provider/supplier for services which were determined to be medically unnecessary or incorrectly and/or improperly billed.
  - This includes any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claim submission, unacceptable practices, fraud, abuse, or mistake.
  - In addition, an estimated overpayment can be assumed by calculating potential claims in error either from billing issues that do not meet Medicaid policy requirements or through an actual medical review of claims.

Extrapolated overpayment

- Obtained by calculating claims denials and reductions typically from an audit of medical records, based on a statistical sampling of a claims universe.

Audits in action: calculating overpayment

- In our example, the MCE calculated an actual overpayment.
- This means that, for the claims reviewed, the sum of the payments (based on the amount paid to the provider and Medicaid approved amounts) made to the provider for services determined to be improperly billed.

Documentation did not support the code billed

- Three claims identified
- Overpayments of $47, $32, $63

Code billed and the frequency limitation has been exceeded

- One claim identified
- Overpayment of $118

Audits in action: calculating overpayment

- Samples 1, 2, 3 and 6 – overpayment.
- Total overpayment = $262.10

Sample	Recipient Name/ Recipient ID	Date of Service	Procedure Description/ Procedure Code	Tooth #	Tooth Surf.	Tooth Surf.	Tooth Surf.	Preliminary Audit Findings	Paid Amount	Correct Amount	Over Payment Amount
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4	Jane Smith	12/1/2017	Post 2 Srfc Resin based Cmpst D2392	14	D	O		No Financial Finding	$46.60	$46.60	$0.00
5	Judy Doe	11/8/2018	Extraction Erupted Tooth/Exr D7140	12	#	#		No Financial Finding	$99.58	$99.58	$0.00
6	Jane Smith	11/15/2018	Post 3 Srfc Resin based Cmpst D2393	15	M	O	D	Potential Financial Finding: •Restoration performed on tooth exceeds frequency limitation for plan in violation of OAR 410-123-1260 (5)(a)(C).	$118.81	$0.00	$118.81

Audits in action: Provider communication

- In our example, the MCE communicated the audit findings and overpayment to the provider in a letter.
  - The provider did not agree with several findings but Dr. S was unable to provide documentation that resolved the findings in the audit.
- Next, the MCE will:
  - Recover the overpayment and adjust encounters
  - Educate Dr. S and dental clinic staff about documentation requirements and frequency limitations
  - In six months, review a random sample of the provider's charts to see if Dr. S is complying with the requirements, and make sure the issues uncovered by the audit are resolved.

Summary

- Audits are fact-finding missions.
- Supporting documentation is critical to proving or disallowing payments.
- Being open, up-front and providing a high level of transparency creates a positive and controlled atmosphere.
- Have trained staff who are familiar with the subject matter performing the audit.
- Successful audits start with pre-planning. Ensure your MCE audit team has foundational audit procedures and plans for all steps of the audit process – from data analysis to provider appeals and overpayment recovery.

Learning from your audits

- Audits can be an opportunity for learning, improvement and prevention.
- The data, payments, and claim edits studied during the audit can identify areas of vulnerability in your organization.

Future audit needs

- Investigations of subcontractors, vendors, and network providers

Operational improvements

- Sanctions or other corrective actions
- Policy changes/ clarifications
- Contract amendments

Your professional growth

- Increase your knowledge
- Increase your proficiency

Contract deliverables

Audits and contract deliverables

- MCEs must send OHA:
  - Quarterly and annual reports of all PI Audits performed. This includes all PI Audits opened, in-process, and closed during the reporting period; and
  - With each quarterly FWA Audit Report, a copy of the final PI Audit report for each PI Audit identified as closed in the reporting quarter.

Reporting overpayments to OHA

- All overpayments, no matter the cause, must be reported to OHA.
- How quickly depends on the circumstances.
- MCE is permitted to keep any sums recovered through the MCE's (or its Subcontractor's) PI Audits or investigations.

Overpayments suspected to be fraud or abuse:

- Report to OHA OPI within 7 days.

Overpayments from PI Audits and investigations:

- Report to OHA OPI in the quarterly and annual FWA reports and in each final PI Audit report.

Recoveries retained by the MCE are reported to OHA in Ex. L.

For all overpayments:

- Adjust, void or replace claims, as appropriate, to reflect the Valid Encounter claim in accordance with OAR 410-141-3570 and Sec. 11-13 of Ex. B, Part 8.
- Maintain records of MCE and Subcontractors' actions related to overpayment recoveries. Such records maintenance must be in accordance with the Contract and made available to OHA and other parties in accordance with Ex. D Sec. 14.

Audits in action: overpayment reporting

- In the audit example, the MCE identified a final total overpayment of $262.10. Next, the MCE will:
  - Recover the overpayment from Dr. S
  - Adjust encounters (as needed)
  - List the PI audit of Dr. S and overpayment amount of $262.10 in the quarterly and annual FWA Audit Report and attach a copy of the MCE's final PI audit report
  - Report the recovered overpayment amount to OHA in the Ex. L Report.