



# The Indiana Family and Social Services Administration

## Program Integrity (PI)

### Medicaid Advisory Committee Meeting

December 11, 2014



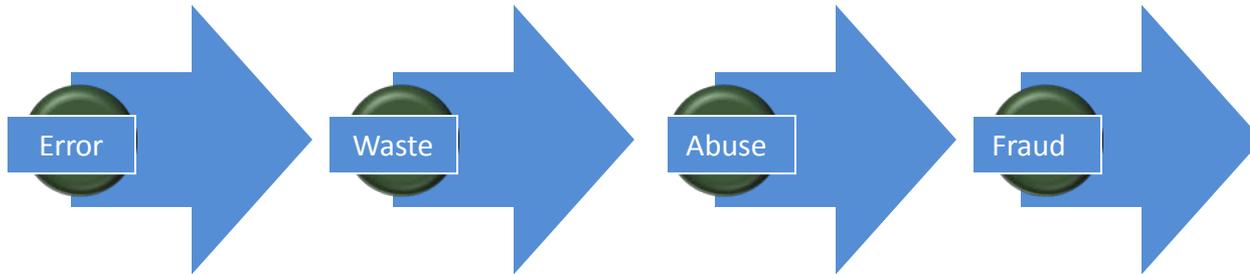
# Agenda

- Program Integrity
  - A range of activities to address and eliminate the causes of improper and fraudulent payment
- Approach
  - Defined, consistent, well monitored
  - Mirrors the continuum with multiple fronts
    - Identification and recovery
    - Correction and prevention
- Goal
  - Making the *correct payment* for the *correct member* for the *correct service* to the *correct provider*.

# Spectrum of Program Integrity

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**Program Integrity** encompasses a range of activities to target the causes of improper and fraudulent payments.



**Examples:**

**Incorrect Coding**

**Inappropriate use and overutilization**

**Medically unnecessary services**

**Billing for services or supplies that were not provided**

# Fraud, Waste and Abuse

- *Fraud* is an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.
- *Waste* is Healthcare spending that can be eliminated without reducing the quality of care.
- *Abuse* is behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary.

# Identification and Assessment

- Sources

- Referrals

- 1-800-457-4515
    - Sister agencies
    - LEIE (List of Excluded Individuals and Entities), OIG and Other States

- Analytics

- Algorithms

- Identification of overpayments

- » Coding violations
        - » System errors

- Surveillance and Utilization Review (SUR) Tools

- Comparisons to peer groups

- » Provider specialties
        - » Use of Codes

- Self-Disclosures



# Identification and Assessment

- Review and Determining Appropriate Action
  - Referrals become Investigations
    - Credible Allegation of Fraud (CAF) Assessment Tool
    - If CAF, then referred to MFCU (Medicaid Fraud Control Unit)
      - MFCU and OGC (Office of General Counsel) affirm allegation and payment suspension commences
    - If not CAF, Risk Assessment completed to determine if provider should be audited and what type of audit is warranted
  - Outcomes of Risk Assessments
    - On-site (announced or unannounced) audit , provider self-audit, or desk audit
    - Recommended for Pre-pay Review
      - Documentation and rules uniformly applied to claims payments and audits

# Identification , Assessment and Action

- Review and Determining Appropriate Action
  - Algorithms
    - Compare paid claims against policy
    - Identify providers who were paid in excess of policy
    - Initiate provider self-audits or
    - Send Draft Audit Findings letters to launch audit
  - Prevention
    - Work with policy group to revise and clarify policy and update Provider Manual
    - Provider Education
      - Banners and Bulletins
    - Feedback to Fiscal Agent- edits
    - Prior authorization

# Audits

## FSSA PI

Bi-Weekly meetings to review risk assessments, audits plan and results; monthly meeting with Medicaid Integrity Contractor (MIC); reviews and approves all audit letters to providers; consults with IHCP policy group to affirm accuracy of responses to requests for reconsideration.

## FSSA PI

Provider Self-Disclosures  
Review, validate and record

Myers and Stauffer (MCLC): on-site, desk and self-audits and E H R audits

Truven Health Analytics- algorithm driven audits

HMS-RAC audits: credit balance and LTC audits

MIC – Medicaid Integrity Contractor: audits coordinated with CMS Region 5

OIG

FSSA Audits

PERM- Payment Error Rate Measurement

# Audit Process

1

- Audit notification and record request for on-site or desk audits
- On-site, desk or provider self-audit
- Record review and preliminary results

2

- Draft Audit Finding or Final Audit Finding (no findings)
- Provider Intent Form-Waiver (agree or disagree with findings)

3

- Request for Reconsideration
- Response to Request for Reconsideration
- Final Audit Finding or Final Calculation of Overpayment

4

- Demand Letter ( if outstanding balance over 300 days)
- Provider ARs created to begin offsets

# Other Program Integrity Work

## Additional Oversight

Managed Care Entities- PI coordination, contract compliance oversight

TPL – contract compliance oversight and review of results

## Hearings and Appeals

Respond to OGC's request for policy clarification, and documentation

Testify at hearings

## Provider Enrollment and Provider Relations

Coordination and communication

**MFCU-** Monthly Coordination Meeting, Vet all providers before audits, Send new referrals. Support investigations and prosecutions as needed.

## CMS

Program Integrity Reviews, Reporting requirements such as SPIA (State Program Integrity Assessment), PERM, CMS-64



Questions

Comments

Thank you for your time and attention.