Medicaid Integrity Program (MIP), Provider Audits
Frequently Asked Questions
July 2009

Background/General Info: (B)

B.1. Where can information on the provider audit program be found?

The most up to date information is posted on our website at http://www.cms.hhs.gov/MedicaidIntegrityProgram. Any documents being sought that are not posted on the website must be requested through the Freedom of Information Act. For more information, please see the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/FOIA/02_requests.asp.

B.2. What Federal statute established the MIP and authority to conduct Medicaid provider reviews and audits?

The Deficit Reduction Act of 2005, signed into law on February 8, 2006, created the Medicaid Integrity Program. The statutory authority for the Medicaid Integrity Program is in Section 1936 of the Social Security Act (42 U.S.C. § 1396u-6).

B.3. What are the objectives of the MIP provider audit program?

To audit provider claims and identify overpayments by ensuring that claims are paid:

- for items and services provided and properly documented;
- for items and services billed using the appropriate procedure codes;
- for covered items and services;
- and
- in accordance with Federal and State laws, regulations, and policies.

B.4. What are Medicaid Integrity Contractors (MICs)?

The MICs are private companies that conduct audit-related activities under contract to the Medicaid Integrity Group (MIG), the component within CMS that is charged by the U.S. Department of Health & Human Services with carrying out the MIP.

There are three primary MICs: 1) the Review MICs, which analyze Medicaid claims data to determine whether provider fraud, waste, or abuse has occurred or may have occurred; 2) the Audit MICs, which audit provider claims and identify overpayments; and 3) the Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

B.5. What Federal regulations exist with respect to the MICs?

Regulations on entities eligible to be MICs and on the limitation of MIC liability can be found at 42 CFR § 455.230 and 455.202, respectively.

B.6. How were the MICs selected?

The CMS conducted a competitive procurement in 2007 to select the Review and Audit MICs. In 2008, CMS conducted a separate competitive procurement to select Education MICs. These procurements resulted in umbrella contract awards to various companies, as described in B.7. Umbrella contracts provide for an indefinite quantity, within stated

limits, of supplies or services during a fixed period. The Government then places task orders for specific requirements under this contracting vehicle.
After making the umbrella awards in the Audit, Review and Education MIC procurements, CMS conducted, and continues to conduct, competitions among the umbrella contract awardees, for the performance of task orders for work in various CMS regions, as described in B.7.

B.7. Who are the MICs and in what CMS regions have they been awarded task orders to do work?

Review MICs are: Thomson Reuters (CMS Regions III & IV); AdvanceMed Corporation (CMS Regions V, VI, VII and VIII); ACS Healthcare Analytics; IMS Government Solutions; and SafeGuard Services.

Audit MICs are: Booz Allen Hamilton (CMS Regions III & IV); Health Management Systems (CMS Regions VI, VIII, IX and X); Fox & Associates; Health Integrity; and IPRO.

Education MICs are: Information Experts and Strategic Health Solutions. At this time, no task orders have been awarded to an Education MIC. Education MICs are not necessarily assigned geographic responsibilities.

B.8. Are the MICs compensated on a "contingency fee" basis?

No. The MICs' compensation is not tied to the dollar amount of overpayments they identify.

B.9. How many audits will the Audit MICs conduct annually?

It is presently difficult to give an estimate, especially since the MIP provider audit program has not been fully implemented in all regions of the United States.

B.10. How many Audit MICs will be conducting provider audits in a given State?

Generally, there is one Audit MIC conducting audits in a given State.

B.11. Do the States oversee the provider audits conducted by the Audit MICs?

No. The Audit MICs provider audits are Federal audits that are overseen by CMS' Medicaid Integrity Group.

B.12. What is the State's role in the MIP's provider audits, as conducted by the Audit MICs?

Generally, the State's role is to: a) verify that MIC audits do not conflict with ongoing program integrity activities; b) review draft audit reports produced by the Audit MICs to ensure that the contractors reached findings in accordance with State and Federal Medicaid laws, regulations, and policies; and c) adjudicate provider appeals.

Identifying Providers for Audits: (I)

I.1. How are providers identified for audit?

The Review MICs run MIG-approved algorithms on claims data from the Medicaid Statistical Information System (MSIS). The MIG's Division of Fraud Research & Detection reviews and approves those results before they are provided to the Audit MICs for audit.

I.2. How does the MIG avoid duplicating other Medicaid audits?

The MIG vets providers to be audited with State Medicaid agencies prior to the start of the audits. The MIG also shares the list of potential audits with State and Federal law enforcement agencies. If either a State Medicaid agency or a law enforcement agency is conducting an audit or investigation of the same provider for similar Medicaid issues, then the MIG may cancel or postpone the Audit MIC audit of the provider.

I.3. Can States recommend providers for audit by the Audit MICs?

Yes.

Audit Process/Procedures: (A)

A.1. Can you describe the process for an audit?

At the beginning of an audit, the Audit MIC sends the provider a notification letter. Most of the audits are desk audits, where the Audit MIC requests provider documentation and reviews the records at the Audit MIC's office. On some occasions, Audit MICs conduct field audits, in which the auditors actually conduct the audits at the provider's location. All audits are being conducted according to Generally Accepted Government Auditing Standards (Yellow Book). If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report which is shared with the State and the provider for comment. Based on these comments, the audit report may be revised. The MIG makes the final decision on any revisions or changes. When the audit report with any associated overpayment is finalized, the MIG sends the final audit report to the State. The State pursues collection of the overpayment from the provider in accordance with the State's laws, regulations, and procedures.

A.2. Are there any Medicaid provider types which are not subject to audit?

No

A.3. Does CMS share Audit MIC audit reports with anyone other than the provider who is being audited?

Yes. The Audit MIC audit reports are shared with the State Medicaid agency. However, as required by law, the reports may also be shared with Federal or State law enforcement agencies.

A.4. How do Audit MICs review questions of medical necessity?

The Audit MICs utilize qualified professionals, including, at a minimum, licensed physicians as Medical Directors and Registered Nurses to conduct medical necessity reviews.

A.5. How many medical or other records can be requested for any particular audit?

The nature of the findings from the claims review dictates the number of records requested. However, as a general rule, the larger volume of records requested, the more likely it is the audit will be conducted onsite at the provider's offices to minimize the impact of copying the records. In some cases, sampling may mitigate the volume of records to be produced.

A.6. How long will the provider be given to produce the records?

As a general rule, the record production period mirrors that of the Medicaid agency in the State in which the audit is conducted. However, it is not likely that more than 45

calendar days would be routinely permitted. The minimum number of days is 15 calendar days, regardless of the State's policy.

A.7. Does CMS or the Audit MIC reimburse the provider for the cost of copying medical records?
No.

A.8. Do the Audit MICs accept imaged or facsimile medical records?
Yes.

A.9. How far back in time will the Audit MICs audit claims?
Generally, the Audit MICs follow the look-back period of the State to which the provider submitted its Medicaid claims. Nevertheless, with MIG approval, the Audit MIC may increase the look-back period.

A.10. Do the Audit MICs utilize sampling and extrapolation?
Yes. Federal law allows for extrapolation. However, Audit MIC sampling and extrapolation decisions take into account the circumstances of the particular audit and the laws and regulations of the State to which the provider submitted its Medicaid claims.

A.11. Is a provider required to make room available for MIC staff during an onsite audit?
Yes. Reasonable requests for space should be honored.

A.12. Can MICs request access to non-Medicaid records or patient account information?
Generally speaking, any provider records which are relevant to validating the Medicaid claims under review are legitimate records and may be requested.

Interaction with law enforcement: (L)

L.1. Are the Audit MICs required to refer suspected fraud to law enforcement?
Yes.

L.2. Is the provider being advised about the referral of suspected fraud?
No. The nature of these referrals requires them to be confidential.***L.3. Does the provider have an opportunity to respond to suspected fraud?***
In the event of a potential subsequent investigation, the provider would be afforded all appropriate legal protection provided in its State.

L.4. Do the Audit MICs respond to requests by law enforcement officials?
Yes, the Audit MICs must cooperate with law enforcement agencies.

Medicaid data used for audits: (D)

D.1. What data do the Audit MICs utilize in the audit process?
The Audit MICs may utilize a variety of data during the audit process, including, but not limited to, Medicaid claims data, recipient medical records, and other provider records.

D.2. Does MSIS data contain every element necessary to conduct appropriate data mining?
Yes. However, the MSIS data submitted by the States to CMS are limited in some respects. For instance, MSIS data does not include the prescription numbers associated with pharmacy claims. Nevertheless, MSIS data does contain many other data elements

– including, but not limited to, recipients' Social Security numbers and dates of birth, prescriber identification numbers, National Drug Code, dates of service – any of which individually or collectively may be used as a claim identifier.

D.3. Are prescription numbers available in MSIS data?

No. As noted above, for the immediate future, pharmacy providers should utilize other claims identifiers. A possible approach to assist providers in retrieving records would involve the utilization of the provider software billing system to generate a report based on the prescription filled date along with the Medicaid recipient's date of birth and/or Social Security number. The CMS is working to rectify the omission of the prescription number and other data elements to allow easier record retrieval by providers.

Overpayment Identification and Recovery: (O)

O.1. Are the Audit MICs responsible for collecting overpayments?

No. The States are responsible for collecting overpayments from providers. This will be done in accordance with the States' respective laws, regulations, and procedures.

O.2. How are Audit MICs involved in the States' adjudication processes?

The Audit MICs support the States' adjudication and collection efforts by providing necessary documents, information, and testimony.

O.3. Do Audit MICs deny claims?

Audit MICs do not "deny claims." All audits conducted by the Audit MICs are post-payment audits. Audit MICs, in their audit reports, identify why specific payments should not have been made to the provider.

Providers: (P)

P.1. How much notice are providers given for an audit?

In general, a notification letter is sent to the provider two weeks before the beginning of the audit. The letter is mailed to whoever is identified in State records as the primary point of contact for the provider. The audit notification letter includes a primary point of contact with the Audit MIC.

P.2. Can a provider identify someone besides the person who is listed by the State records to be the primary point of contacts for an audit?

Yes. The provider should so notify the lead auditor for the Audit MIC.

P.3. Do the Audit MICs conduct entrance and exit conferences?

Generally, yes. However, not all types of audits require entrance or exit conferences. When held, the entrance conference explains the objectives of the audit and attempts to addresses questions from the provider. When held, the exit conference offers general observations on the audit findings. Specific overpayments will not be discussed. Entrance and exit conferences may be conducted in person or via teleconference, depending on whether the audit is a field or a desk audit.

P.4. Does the provider have an opportunity to review the audit report before it is finalized?

The Audit MICs draft audit report is shared with the provider for comment before being finalized.

P.5. May the provider challenge the findings of the final audit report?

The provider may exercise whatever appeal or adjudication rights are available under State law when the State adjudicates and seeks to collect the overpayment identified by the Audit MICs final audit report.

P.6. Whom should the provider or its representative contact with questions about the conduct of a specific audit?

Questions about specific audits should be directed to the lead auditor for the Audit MIC. Questions about the Medicaid Integrity Program or the Audit MICs themselves can be sent to Medicaid_Integrity_Program@cms.hhs.gov.

P.7. How are potential conflicts between State Medicaid laws, regulations, and policies and Federal law, regulations, and policies being resolved?

The MIG will address these issues with the States.

P.8. May the provider be audited by multiple oversight bodies, such as the Audit MIC, the State Medicaid agency, Medicare contractors, or the Inspector Generals of the State or the U.S. Department of Health & Human Services?

Yes, this is possible, especially if the audits cover different programs (e.g., Medicaid versus Medicare), different audit issues (e.g., one-day stays versus post-mortem payments) or different audit periods.

Miscellaneous: (M)

M.1. Are the MICs required to comply with provisions of the Federal Privacy Act and the Federal Health Insurance Portability and Accountability Act (HIPAA)?

MICs are contractually obligated to comply with HIPAA. As our contractors, the CMS records that the MICs maintain on CMS' behalf are subject to the Privacy Act.

M.2. Do Review or Audit MICs need a HIPAA business associate agreement to have access to patient protected health information?

No, the MICs do not need a business associate agreement with providers to get protected health information from providers.

M.3. What record retention guidelines apply to the MICs?

Audit and Review MICs must maintain records and files in accordance with the National Archives and Records Administration (NARA) record retention criteria found in sections 1220-1238, Code of Federal Regulations Title 36.

M.4. How do the Audit MICs handle FOIA requests?

The MICs will handle FOIA requests in accordance with Federal law and CMS policies and procedures. For more information on making FOIA requests, please see the CMS website at http://www.cms.hhs.gov/FOIA/02_requests.asp.