

MEDICAID PROGRAM INTEGRITY MANUAL
CHAPTER 10 – MEDICAID INTEGRITY AUDITS

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10000 – BACKGROUND

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Audit Medicaid Integrity Contractors (Audit MICs) are private companies that conduct audit-related activities under contract with the CMS MIG. Audit MICs conduct post-payment audits of all types of Medicaid providers and, where appropriate, identify overpayments.

10005 – BASIS OF AUTHORITY - STATUTORY/REGULATORY CITATION

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Section 1936 of the Act, established by the Deficit Reduction Act of 2005, is the statutory authority under which the Audit MICs operate. Section 1936(a) provides that the Secretary must enter into contracts to conduct certain activities specified at section 1936(b). Sections 1936(b)(2) and (3) provide that the CMS' contractors can audit claims for payment for items or services furnished under a State plan and can identify overpayments made to individuals or entities receiving federal funds under Medicaid. The CMS' Audit MICs perform these functions.

In addition, section 1936(b)(1) provides that the CMS' contractors can review the actions of individuals or entities furnishing items or services for which payment may be made under a State plan to determine whether fraud, waste, or abuse has occurred or is likely to occur. Although this function is, in large measure, the responsibility of the Review MIC, the Audit MICs share the ongoing responsibility to assess during the course of an audit whether audit findings suggest the possibility of fraud, waste, or abuse and, if so, to make an appropriate referral to law enforcement. The Review MIC conducts data mining analysis and algorithm development to identify potential provider overpayments in various program areas. The identified providers are vetted extensively with Federal and State law enforcement entities, the State Medicaid Agency, and Medicare to determine if they are already under review or investigation. Following the vetting process the Audit MICs are assigned the providers and provided the claims information from which to audit.

10010 – PURPOSE

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The objectives of the MIC audits are to audit provider claims and identify overpayments by ensuring that claims are paid for items and services provided and properly documented; that items and services are billed using appropriate procedure codes; and the covered items and services are paid in accordance with Federal and State laws, regulations and policies.

10015 – AUDIT DEFINITIONS

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Focused Desk Reviews – Focused desk reviews are conducted at the auditor’s desk and are based primarily on the findings from rules-based algorithms and a review of medical records that the provider faxes, scans, or mails to the auditor. These rules- based algorithms generate lists of like-problem claims, sorted by provider, with relevant transaction details. The focused desk review will center on the specific claims in dispute identified by the algorithm.

Focused Field Audits – Focused Field Audits are audits that are also based primarily from the findings from rules-based algorithms. These are similar to the focused desk reviews in that a single question may be at issue although there may be several questions at issue if the provider has been identified under several algorithms. Because of questions that arise with respect to the number or type of issues and the volume of claims, a field visit to a provider’s premises is deemed by the MIG to be appropriate. This visit is made for a specific reason such as on-site documentation collection is required, or the actual service provision or business processes must be observed, or there is reason to believe that an accurate appraisal of the facts will only be gathered with a site visit.

Comprehensive Audits – Comprehensive audits are detailed investigations of all areas relevant to the proper payment of Medicaid funds to the provider being audited. In the conduct of these audits, the MIC receives initial direction from the MIG, but is also allowed to take the audit in any direction that suspect data leads them. Comprehensive audits will, under most circumstances, take place on a provider’s premises where on-site documentation is required or actual services or business processes (e.g., hours of operation, site exists, products or services are available) or must be observed by the Audit MIC. These audits may also involve auditing a variety of complex suspect activities (e.g., medical necessity, review of all therapy-related services in an outpatient clinic). Comprehensive audits will also include auditing for Third Party Liability (TPL) and usual and customary charges.

10020 – FRAUD REFERRALS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Through the course of conducting an audit of a provider or institution, the Audit MIC may identify potential Medicare or Medicaid fraud. The Audit MIC is required to simultaneously and immediately make a fraud referral to the MIG and the OIG. The OIG is to notify and provide information to the appropriate MFCU within 14 days of receiving the referral. The OIG has 60 days to determine whether to accept the referral. The OIG will notify the MIG of any declination at that time or report quarterly thereafter on cases that it accepts. The Audit MICs are required to cooperate with all reasonable requests for assistance from the OIG and MFCU. Section 1936(c)(1)(B) of the Act and 42 CFR 455.230(b) requires cooperation with law enforcement. The Audit MIC Statement of Work requires all suspected fraud to be referred to the OIG.

The Audit MIC will continue with the audit and will not disclose to the provider at any time during the course of the audit that there is a suspicion of fraud or abuse or that a referral has been made. The Audit MIC will not report any audit results to anyone other than the MIG (i.e., will not report the draft findings to the provider or the State) without MIG and OIG approval.

10025 – AUDIT REVIEW PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

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. If concerns arise, a provider may send specific questions or concerns regarding an Audit MIC to [Medicaid Integrity Program@cms.hhs.gov](mailto:Medicaid_Integrity_Program@cms.hhs.gov). 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. A State agency may send specific questions or concerns regarding an Audit MIC to their assigned CMS MIG Audit Liaison. 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.

10030 – LOOK BACK PERIOD

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The Audit MIC is to comply with the following directions when preparing to engage the provider to be audited. The Audit MIC is to send the provider an engagement letter and a request for records. Effective October 1, 2010 the look back period when requesting records must be for 5 years from the start of the audit (date the engagement letter is sent to the provider). For example, if an audit begins in October 2010, the look back period for reviewing claims and request for records would go back to October 2005.

10035 – REQUEST FOR RECORDS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

When making the request for records, the Audit MIC must allow the provider 30 days to produce the records, with a permissible 15-day extension if requested by the provider.

10040 – DOCUMENTATION OF FINDINGS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

All audit findings must be supported by adequate documentation. Adequate documentation consists of documents obtained by the auditor during the course of the audit and should be part of the audit working paper file. The working paper file contains evidence accumulated throughout the audit to support the work performed, the results of the audit, including adjustments made and the judgment of the auditor.

Examples of documents are:

1. Copies of Federal and/or State policies and regulations;
2. Copies of medical/financial records to support the finding;
3. Copies of State generated Remittance Advices which support the claim payment or credit adjustment;
4. Correspondence, such as Provider Notification Letters and Record Request Letters/Lists;
5. Auditor's notes regarding the audit; and
6. Miscellaneous memoranda that pertain to the audit.

10045 – AUDIT RESOLUTION PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Draft audit reports (DARs) are sent to the State Medicaid Agency for a 30-day review and comment period. State comments are considered by the MIG and the Audit MIC and, as necessary, the DAR is revised to account for these comments. The revised DAR, or original DAR if the State review did not necessitate a revision, is then transmitted by the Audit MIC to the provider for a 30-day review and comment period. The MIG and the Audit MIC review provider responses, if any, to determine if further revision is necessary to the DAR, after which the Revised Draft Audit Report (RDAR) is again sent to the State, this time with a 15-day review and comment window. The MIG, the Audit MIC, and, if necessary, the State reconcile any issues with the RDAR, after which the Audit MIC produces a Final Audit Report (FAR). The MIG, upon approving the FAR, sends the FAR to the State. The FAR identifies the total overpayment amount paid to the provider and specifies the amount of FFP that the State must return. It is the State's responsibility to adjudicate the audit findings with the provider. The State has 1 year from the date the overpayment is identified to recover or attempt to recover the overpayment from the provider before the Federal share must be refunded to CMS. Under CMS' regulations, the discovery date for overpayments begins on the date of the final written notice of the State's overpayment determination to the provider. (42 CFR § 433.316).

10050 – STATE COORDINATION & JOINT OPERATING AGREEMENTS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

Before providing an Audit MIC with an audit assignment, the MIG vets the providers identified for audit with partners and stakeholders in the State. This includes State Medicaid agencies, State and Federal law enforcement agencies and Medicare contractors. These entities are provided a list of potential audits generated by the data analysis mentioned above. If any of the audit partners and/or stakeholders within the State is conducting an audit or investigation of the same provider for similar Medicaid issues, the MIG may cancel or postpone the Audit MIC audit of the provider. In this way, the MIG avoids duplicating the efforts of other Medicaid audits.

Further, each Audit MIC is to establish a Joint Operating Agreement (JOA) with each State Medicaid Agency within their Task Order. The JOA is to help States understand how the Audit MIC will carry out its responsibilities as auditors of Medicaid providers as well as what the State's role is in assisting the Audit MIC. The JOA covers such areas as communication, dispute resolution, audit planning, audit report process, avoiding conflict of interest, fraud referrals and data issues.

10055 – STATE APPEAL PROCESS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

The CMS does not dictate the process by which MIP audit findings are appealed. Rather, appeal processes are determined by each State and are subject to the State's Medicaid program requirements. State Medicaid Agencies must defend MIP audit findings in administrative appeal or judicial proceedings as if they are their own, although the Audit MIC may provide testimonial support and other assistance to the State to defend audit findings throughout administrative or judicial proceedings. States that wish to challenge the findings of a FAR can do so by filing an appeal through the HHS Departmental Appeals Board Appellate Division.

10060 – CLOSE OUT LETTERS

(Rev. 1, Issued: 09-23-11, Effective: 09-23-11, Implementation: 09-23-11)

- Upon completion of an audit, the Audit MIC will issue either an audit report or a close out letter. The close out letter provides notification to the provider that the audit has been stopped for reasons other than identification of overpayments. The Audit MIC is responsible for obtaining MIG clearance prior to issuing a close out letter. Upon approval, the Audit MIC sends the close out letter to the provider in question, and sends copies to the State and the MIG.

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