MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)

RECOVERY AUDIT CONTRACTOR (RAC)
AUDIT PROCEDURES AND PROTOCOLS

Version 3
August 2018

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Myers and Stauffer LC ("MSLC"), with the approval of the Georgia Department of Community Health ("DCH" or "the Department") Inspector General, has adopted the following general Audit Procedures and Protocols for the performance of audits under the Recovery Audit Contractor (RAC) program. These Audit Procedures and Protocols may be revised and/or supplemented during the pendency of the RAC program.

Providers who have questions about these guidelines may contact MSLC through the Georgia Medicaid RAC toll-free number (1-855-201-4570) or by email to: GA_RAC@mslc.com.

These Audit Procedures and Protocols, as well as general information about the Georgia Medicaid RAC program, are also available at the MSLC website: http://www.mslc.com/Georgia/MedicaidRAC.aspx.

I. Identification of audit issues or subjects

(a) Generally

Georgia Recovery Audit Contractor audits may involve reviews of claims for services by any or all providers in any category of service (COS) provided under Georgia's Medicaid program. (A complete list of these categories of service may be found in Appendix A, of *Part I, Policies and Procedures for Medicaid/Peachcare for Kids*™.) As Georgia's Medicaid RAC, MSLC identifies audit issues or subjects in consultation with the Department and all Medicaid RAC audits are subject to the final approval of the Department. No finding of "good cause" is required for the initiation of a Georgia Medicaid RAC audit.

(b) RAC Initiated Audits

MSLC uses its knowledge and experience with Medicaid policies and procedures, audits, various analytical tools, consultation with DCH and Subject Matter Experts (SMEs), research, and its monitoring of health care news and developments to identify services and providers to be subject to analysis or audit.

(c) Referrals from other sources

MSLC also receives referrals from various sources, including but not limited to, DCH; Georgia Medicaid's Care Management Organizations (CMOs); the Georgia Medicaid Fraud Control Unit ("MFCU"); the Georgia Medi Medi contractor; the United States Department of Health and Human Services – Office of Inspector General; the Department of Justice; the Centers for Medicare and Medicaid Services (CMS); Medicare RACs; and other contractors, vendors and insurance companies which perform health care audits.

II. Preliminary Review

(a) After an issue or subject has been identified, MSLC researches the applicable Medicaid policies and procedures and other sources of guidance, conducts a preliminary data analysis and obtains preliminary information about the providers to determine whether further review or an audit is warranted.

MSLC conducts extensive research into the laws, regulations and policies governing Medicaid reimbursement and consults with DCH and SMEs to ensure that Georgia Medicaid RAC audits of Medicaid claims are conducted under full and accurate guidance. (For more information on guidance in audits involving clinical reviews, see Section V below.)

Preliminary data analysis includes the dollar amount and numerical volume of claims, number of providers, billing trends, potential overpayment or underpayment, and other data indices.

This stage of the review also includes preliminary information about any of the providers potentially subject to the audit, including but not limited to:

(1) The length of time the provider has been enrolled in the Georgia Medicaid program;

(2) Whether the provider has been the subject of past audits by MSLC, DCH or other auditing entities and whether any repayments or adverse actions resulted;

(3) Whether the provider is under investigation by the Georgia Medicaid Fraud Control Unit or any other investigative or law enforcement entities;

(4) The number of locations the provider is operating;

(5) Whether the provider's billing patterns represent outliers compared to other providers in the same category of service;

(6) Whether there is any information suggesting the occurrence of improper billing or indices of fraud and/or abuse.

(b) When policy review, data analysis and provider information indicate that an audit should be performed, MSLC performs a risk assessment for the purpose of determining what type of audit to perform. Such assessment includes consideration of other factors, including but not limited to:

(1) The volume of claims and number of providers involved;

(2) Whether it is possible to determine mispayments without the review of medical, financial or other records;

(3) Whether the audit will involve issues of medical necessity and, if so, whether such issues can be addressed by MSLC's medical director and/or clinical reviewers or whether additional specialized expertise will be required;

(4) For audits requiring the review of medical, financial or other records, the level of expertise and credentials of any other reviewers required, and additional resources which may be required to complete the audit;

(5) An estimate of the potential Return on Investment (ROI) if a specific type of audit is pursued.

III. Types of Audits

(a) If the preliminary analysis and risk assessment indicate that an audit is warranted, after further consultation with the Department, MSLC will recommend performance of one of the following types of audits:

(1) An "automated" review – a review of claims that does not include a review of medical or other records;

(2) "Complex" desk review – a review of claims that includes a review of medical, financial and/or other records requested from the provider;

(3) "Complex" onsite review – a review of claims that includes a review of medical, financial and/or other records obtained while MSLC is onsite at the provider's location;

(4) Under appropriate circumstances, at the discretion of MSLC and with the approval of DCH, a preliminary "automated" or "complex" review may result in a request that a provider perform a provider "Self-Audit" in accordance with General Guidelines for Provider Self-Audits (see Appendix A for further information about such Guidelines);

(5) "Special audits" - customized audits for reviews involving unique or complex issues.

(b) Other Audit Issues

(1) Time period for audits

Pursuant to the State Plan Amendment (SPA) approved by the Centers for Medicare and Medicaid Services (CMS), Georgia Medicaid RAC audits may involve a "look back" period of up to five years.

(2) Benefits Recovery Control Number

At the initiation of an audit, MSLC requests that the DCH Office of Inspector General assign a Benefit Recovery Control Number to each provider who is a subject of the audit.

(3) Use of statistical sampling and extrapolation

Subject to the approval of DCH and on a case-by-case basis, Georgia Medicaid RAC audits may in appropriate circumstances use statistically valid sampling and extrapolation to determine amounts of overpayments. Extrapolation is only appropriate when the error rate of the sample is deemed high by the auditor and confirmed by DCH. The auditor should consider the variability in the claims when stratifying and selecting the sample. If approved, such process will be conducted after consultation with and upon the advice of a qualified statistician and using generally approved statistical software, such as the HHS-OIG's RATS-STAT. Recovery amounts shall be limited to the lower bound of the confidence interval.

(4) Coordination of audits

In consultation with DCH's Inspector General, MSLC coordinates with other auditing entities to avoid duplicative audits which may be burdensome on providers. A provider who receives notice of a Georgia Medicaid RAC audit which appears to duplicate a completed or pending audit should notify MSLC via toll-free number or in writing. Audits which address different services, issues, claims or time periods are not considered duplicative.

IV. Performance of Audits

(a) Obtaining and Reviewing Medical, Financial and Other Records

For a complex audit involving a review of medical, financial and/or other records, a Request for Records will be sent to a provider and that provider will typically have thirty (30) days from the date of the Request to provide the documentation. In audits involving complex or voluminous records, MSLC will work with providers to ensure a reasonable production process which is not unduly burdensome to providers. (For limitations on the number and frequency of medical record requests, see Section V(d)(2) below.)

Providers are encouraged to produce records in a HIPPA compliant secure electronic format, including imaged records on CD/ DVD, SFTP etc. If a provider requests to submit medical records via facsimile, a secure machine must be utilized. Electronic records should meet the following requirements:

(1) Scanned images must be at least 200 dpi and in black and white. Color is also acceptable;

(2) Multipage documents must be in one image; e.g. a ten page document should be provided as one imaged file;

(3) Data should be stored in a Database or Excel file format, or otherwise provided in a fixed format sequential file in ASCII;

(4) All data and records should be clearly labeled and include the provider's name, Medicaid number, date and MSLC tracking number;

(5) MSLC will accept electronic data by Flash drives, compact disks, or via facsimile.

For the purpose of ensuring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and all other privacy and confidentiality laws, regulations and policies, MSLC will offer and instruct providers on the use of Secure File Transfer Protocol (SFTP) transmission and will create SFTP accounts for providers who request an account be established for audit record submission purposes.

Providers who use electronic health records (EHR) may be asked, in appropriate circumstances, to produce copies of their policies which: (a) define how access to the records is granted and monitored; (b) how entries and updates to the EHR are logged and tracked; and (c) how electronic signatures within the EHR are validated.

Providers submitting paper records must ensure that copies are of good quality and one-sided only, and that papers are free of staples, paperclips and other fasteners.

Providers are encouraged to number records by Bates stamp or similar method.

MSLC is not required to pay for the costs of record copying or production.

MSLC will receive, maintain and transmit all medical records in compliance with HIPAA, HITECH and other Federal and State privacy and confidentiality laws and regulations.

Providers must also ensure that the transmission and production of records comply with all such applicable laws, regulations and policies.

(b) Review Procedures

Pending receipt of records, MSLC will develop an audit methodology, including appropriate audit checklists and/or other work papers to be used in Desk Reviews, Onsite Audits, or Special Audits.

Following production of the medical, financial or other records, MSLC will complete its review and issue an Initial Findings Letter to each provider, including one or a combination of the following determinations:

(1) Claims were properly paid;

(2) Claims were overpaid, based on specific policy violations, resulting in a proposed recoupment;

(3) Claims were underpaid, resulting in a proposed additional payment to the provider.

The Initial Findings Letter will also include a claims discrepancy table which provides additional details about claims reviewed and payment instructions.

(c) Referral of cases involving suspected fraud and/or abuse

When in the course of selecting claims for audits, or during the performance of an audit, MSLC becomes aware of information indicating suspected fraud and/or abuse, MSLC will promptly refer such information to the Department of Community Health Office of the Inspector General.

(d) In the event of a finding of an apparent overpayment, a provider may:

(1) Accept the findings, in whole or in part; and/or

(2) Request an administrative review of such findings, or a portion thereof, by submitting a request in writing within thirty (30) days of the date of the Initial Findings Letter. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and explanation that the provider wishes to be considered. Letters requesting Administrative Review that are not accompanied by supporting documentation will not be accepted or considered. MSLC may at its discretion re-audit a provider who submits additional documentation.

MSLC will include in the Initial Findings Letter a form response which sets forth these response options. This form response, as well as any additional records or information a provider wishes to submit in support of the request for administrative review, must be returned within thirty (30) days to:

Myers and Stauffer LC
Attention: Vicki Bartlett
133 Peachtree Street, NE – Suite 3150
Atlanta, GA 30303

(e) Following receipt of an acceptance of findings or completion of Administrative Review the auditor will send a "Final Decision with Payment Instructions" letter to the provider. While there is no set timetable for the issuance of the Final Decision, MSLC will make every effort to do so in a reasonably expeditious manner.

A provider should not submit an adjusted claim, void a claim or remit payment during the pendency of any review unless or until instructed to do so. The Final Decision letter will contain important information for tracking repayments and accounting.

(f) In the event that a provider fails to respond to the Initial Findings Letter and there is proof of delivery of such letter to the provider, MSLC will send a Failure to Respond and Notice of Intent to Recoup letter to the provider, which contains payment instructions.

(g) Full payment must be received or a provider repayment plan must be in place within thirty (30) days of the date of the final decision letter. If remittance is not received or repayment plan not established on or before such date, DCH will deduct the full amount from payments to the provider and/or implement other appropriate recovery actions. When sending payment advise providers to reference their provider ID, payee ID, and Benefit Recovery Control Number to

ensure proper accounting.

Providers seeking to obtain an extended payment schedule must first complete the Repayment Plan Form located on the DCH website (https://dch.georgia.gov/). The form can be accessed from the providers tab on the homepage. Email inquiries for questions applicable to repayment may be sent to AR-inquiry@dch.ga.gov.

(h) MSLC submits all provider letters or notices to the DCH Inspector General for prior approval. All letters containing PHI are sent certified mail, return receipt requested, through the DCH Office of Inspector General.

(i) A provider may appeal a Final Decision by requesting a hearing before an Administrative Law Judge (ALJ) in accordance with procedures set forth in Chapter 500, Part I, *Policies and Procedures for Medicaid/PeachCare for Kids*™. In such cases, MSLC will provide expert witnesses to testify at the ALJ hearing. Section 506 provides that the Request for Hearing must be sent within fifteen (15) business days after receipt of the Final Decision to:

Georgia Department of Community Health
Legal Services Section
40th Floor, Two Peachtree Street, NW
Atlanta, Georgia 30303-3159

Section 506 also provides in pertinent parts that the Request for Hearing must include the following information:

- A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law Judge.
- Identification of the adverse Administrative Review decision or other Division action being appealed and all issues that will be addressed at hearing. Issues at hearing are limited to those issues that have been submitted for Administrative Review.
- A copy of the Adverse Action Letter, Administrative Review Response, or Final Denial Notice.
- A specific statement of why the provider believes the Administrative Review decision or other Division action is wrong.
- A statement of the relief sought.

Providers should review all Chapter 500 requirements for perfecting and pursuing an appeal.

V. Complex Audits Involving Clinical Issues

(a) Scope

"Complex" audits include reviews of medical records for claims which raise utilization, medical necessity, levels of care and/or other clinical issues. While many of these reviews will involve hospital and physician services, other reviews may involve any of Georgia Medicaid's other categories of service, including but not limited to, services such as durable medical equipment (DME), physical, occupational and speech therapy, nursing home, hospice, psychological services, dental and others.

(b) Staffing of the MSLC Georgia Medicaid RAC Clinical Team

The Georgia Medicaid RAC Clinical Audit Team includes a Medical Director who oversees

clinical reviews. Registered Nurses and certified coders will make up the core of the Georgia Medicaid RACs clinical staff and will be assisted by other Georgia Medicaid RAC team members, including auditors and data analysts.

In compliance with both Federal law and the Medicaid RAC Contract with the State of Georgia, the Georgia Medicaid RAC team will ensure that audits requiring a determination of medical necessity will be conducted by licensed, board certified or board eligible physicians of the appropriate specialty in medicine, osteopathy, dentistry or psychology located in Georgia who have active admitting privileges in a hospital in the State.

(c) Guidance

Medicaid providers are responsible for complying with various sources of guidance applicable to claims submitted to the Medicaid program, including but not limited to: (1) Federal and State law and regulations; (2) Georgia Medicaid policies, including Part I policies applicable to all enrolled providers and Part II policies applicable to specific categories of service; (3) professional standards; and (4) coding guidelines, including the Current Procedural Terminology, International Classification of Diseases and HCPCS manuals which were applicable on the dates of service billed.

Core clinical guidelines are set forth in Section 106, *Part I, Policies and Procedures for Medicaid/Peachcare for Kids*™, which provides that all Medicaid providers must:

(1) Not engage in any act or omission that constitutes or results in overutilization of services;

(2) Neither bill the Division for any services not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information to the Division relating to provider costs, claims or assigned certification numbers for services rendered;

(3) Bill the Division for only those covered services that are medically necessary and within accepted professional standards of practice;

(4) Maintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services (emphasis added).

Part II policies set forth additional requirements for specific categories of service. For example, Section 902.2, *Part II, Policies and Procedures for Physician Services*, requires that physicians "select the procedure code(s) which most nearly describes the procedure(s) performed" (emphasis added).

Professional standards of practice and evidence based guidelines have been developed by research and government organizations such as: the United States Preventive Services Task Force; the National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC); World Health Organization (WHO); *Agency for Healthcare Research and Quality (AHRQ);* and various physician specialty associations including the American Academy of Family Physicians; the American College of Physicians; the American College of Emergency Physicians; the American College of Cardiology; the American Academy of Allergy, Asthma & Immunology; the American College of Radiology; the American Society of Nephrology; and others. These guidelines and standards of practice may be applicable to certain types of audits.

Under the supervision of the Medical Director, the Georgia Medicaid RAC clinical team will draw from these sources and others, including current peer-review journals and peer-reviewed and/or edited specialty textbooks to determine the clinical criteria applicable to a

specific audit. The team will also utilize InterQual™ evidence based clinical guidelines and software to determine the propriety of utilization, medical necessity, level of care and required documentation.

(d) Requests for Medical Records

(1) Generally

The scope of the clinical review and the number of records requested and reviewed will vary dependent upon the audit issues presented. For example, the medical necessity review for a simple drug screen will involve a much more focused review than would the medical necessity review of a major surgical procedure.

The clinical team, under the direction of the Medical Director, will determine the scope of the clinical review and parameters of the record request when the audit plan is finalized. Every effort will be made to limit requests for records to those which are necessary to complete the specific review.

The general guidelines for request for records and submission of records will apply to clinical reviews. However, when voluminous records are requested for desk reviews, the auditor has the authority to offer one extension of the 30-day production period, if necessary, upon a provider's request.

(2) Limitations on the Number and Frequency of Medical Record Requests

For the purposes of establishing limitations on the number and frequency of medical records that can be requested for a Georgia Medicaid RAC audit, "one medical record" is defined as all medical documentation for one Medicaid member's continuous episode of treatment performed at one location. For example, hospital records for a member's two-week inpatient treatment would constitute "one medical record", as would the medical chart notes for a brief office visit to a physician.

The limitation on the number and frequency of medical record requests applies to each of a provider's rendering provider numbers (not payee numbers). Therefore, if a provider performs services at "A" and "B" locations, the limitation applies to each location.

The numerical limit is based on the number of a provider's Medicaid claims during the prior calendar year, without regard to the type of claim.

The frequency limitation is based on the number of requests made within a 60-day time frame.

The Georgia Medicaid RAC team may request from a provider the lesser of: (1) one percent of the total number of claims submitted by the provider during the previous calendar year; or (2) 350 medical records every 60 days; however, such minimum number shall in no event be less than 100 records.

The Georgia Medicaid RAC may request, and the Department of Community Health may approve, exceptions to these limitations as needed to perform selected types of audits.

(e) Performance of a Clinical Review

The Georgia Medicaid RAC clinical team will review Medicaid claims to determine if such claims were properly paid based upon the guidance determined to be applicable to the services billed by the provider(s).

The issues presented in specific audits will vary, but may include issues such as:

- Were the services performed and delivered in compliance with all applicable Georgia Medicaid Part I and Part II Policies and Procedures?
- Were the services for which claims were submitted and reimbursed medically necessary?
- Did the services meet accepted professional standards and/or evidence-based clinical guidelines?
- Were any claims submitted for services that were not performed or documented?
- Were claims submitted for services that were over utilized, on the basis of applicable guidelines, standards, or references?
- Were claims submitted for services that were performed in excess of any applicable policy limitations on the number of units, items or services during certain periods of time?
- Were any errors or amendments in patient records corrected in compliance with currently accepted standards of medical practice?
- Were the services billed under the procedure code(s) which most nearly describes the procedure(s) performed?
- Was the number of units billed equal to the documented units of service performed?
- Was there clinical support for the frequency, duration, and amount of the billed services or items?
- Was the use of coding modifiers appropriate for the services performed?
- With respect to physician office visits, did Evaluation and Management services meet the criteria corresponding to the levels of service actually performed?
- Was appropriate oversight both demonstrated and documented for services provided by physician extenders?
- Were physician orders entered and signed when required for the services and treatment performed and billed?
- Were the technical and professional components of radiological services properly billed?
- With respect to hospital services, did member patients meet criteria for observation vs. admission?
- With respect to hospital inpatient services, were the diagnoses, procedures, and other factors that impact the Diagnosis-Related Group (DRG) appropriate, valid for the treatment performed, and correctly documented within the medical record?
- With respect to surgical procedures, were services properly included or excluded from the bundled global surgery fee?
- For Neonatal Intensive Care Unit (NICU) services, did the claims properly reflect the

medically necessary level of care?

Following the review of claims and the medical records by the Georgia Medicaid RAC clinical team, the team will determine whether any potential overpayments or underpayments to the Medicaid provider(s) occurred. MSLC will send an Initial Findings Letter to the audited providers and thereafter the general audit process will be followed.

(This section intentionally left blank.)

Appendix A: General Guidelines for Provider Self-Audits

In certain circumstances subsequent to a preliminary "automated" claims review or at any time during a complex review, Myers and Stauffer LC ("MSLC") may, after consultation with and the approval of the Department of Community Health ("DCH"), request that a provider perform a self-audit, in accordance with the following procedures:

1. MSLC will issue to the provider a Request for Self-Audit letter that will include, at a minimum, the following information:

   (a) Identification of the types of claims to be reviewed, time period of such claims, total number of claims and total dollar amount paid by Medicaid for such claims;

   (b) A summary of the issues raised by the audit to date and identification of the policies and procedures which apply to the claims at issue;

   (c) A sampling plan developed by MSLC or, at the discretion of MSLC, a request for the provider to develop and propose its own sampling plan. A sampling plan should include the total number of claims to be reviewed, the methodology for reviewing such claims, whether or not a statistically valid sample and projection will be utilized, a description of the credentials of the reviewer(s), and an estimate of the time needed to complete the audit.

2. Approval of the Self-Audit Plan is at the sole discretion of MSLC and may not proceed without the written approval of MSLC. In the event that a provider declines to perform a Self-Audit, then MSLC may proceed with its own audit or review of the provider's claims.

3. Following approval of the Self-Audit Plan, a provider shall perform the Self-Audit and report the results in writing to MSLC within the time limit noted within the Self-Audit notification. With respect to complex or lengthy audits, MSLC may request periodic progress reports, copies of work papers, or other documentation used in the provider's Self-Audit.

4. Corrective Action

   The appropriate management of the audited provider should review the audit findings to ensure that changes will be made in policies and procedures to correct future errors involving the same issues raised by the audit. For all errors identified, a corrective action plan must be submitted to MSLC and to the DCH Inspector General.

5. Validation

   Following completion of the provider Self-Audit, MSLC may elect to validate the audit results by reviewing some or all of the claims and documentation reviewed by the provider or additional claims not reviewed by the provider. In appropriate circumstances MSLC may accept the results of the Self-Audit without validation, though this is expected to be rare. Finally, in some circumstances MSLC may reject the results of the Provider Self-Audit and initiate alternative audit procedures, including, at the discretion of MSLC, an onsite audit.

6. Findings

   Following submission of the provider's report of the Self-Audit and the conclusion of validation of the Self-Audit by MSLC, MSLC will issue an Initial Findings Letter to the provider.

7. Administrative Review and Appeal

   Following issuance of the Initial Findings Letter, a provider may request an administrative review and a subsequent hearing before an administrative law judge in accordance with the procedures applicable to all Georgia Medicaid RAC audits.