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### **About the Wiggin and Dana Health Care Department**

For decades, Wiggin and Dana has been home to one of the largest, most extensive and experienced health law

## **Coming Soon to a Provider Near You: Medicaid Recovery Audit Contractors and Medicaid Integrity Contractors**

Recent federal legislation authorized two new government-contracted Medicaid auditors: Medicaid Recovery Audit Contractors ("Medicaid RACs") and Medicaid Integrity Contractors ("MICs"). Medicaid RAC and MIC audits will be in addition to, and will not replace, state Medicaid audits or Medicaid integrity initiatives. Medicaid RACs are expected to begin auditing providers in 2011 and limited MIC activity is already underway in Connecticut. While many of the details regarding how the Medicaid RACs and MICs will conduct their audits are still unknown, providers will be required to produce documents and may also be required to give interviews, provide tours of their facilities, and perhaps even respond to allegations of improper billing. Medicaid RACs and MICs undoubtedly will be aggressive, and providers need to be prepared to deal with them.

### **Medicaid RACs: Medicaid Recovery Audit Contractors**

Background. The Medicare RAC program received huge amounts of press and notoriety primarily because of the program's contingency-based compensation. Like bounty hunters, Medicare RACs are paid a percentage of the improper payments they identify, which many believe creates an incentive for the RACs to be overly aggressive. Some have commented that the RACs appropriately share their name with the ancient medieval racks, which were torture devices used to stretch victims' limbs until they were torn apart.

Despite the negative reception of the provider community to the Medicare RACs, the Patient Protection and Affordable Care Act (PPACA) of 2010 expanded the RAC program to encompass Medicaid. Each state must contract with at least one Medicaid RAC for the identification of overpayments and underpayments and for the recoupment of overpayments. Medicaid RACs must be paid on a contingency fee basis for the collection of overpayments, but states will have discretion in determining how to pay Medicaid RACs for the identification of underpayments. On October 1, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a letter to all state Medicaid Directors directing states to implement their Medicaid RAC programs by April 1, 2011.

Procedures. CMS is required to issue regulations specifying how the Medicaid RAC audits will be performed. Some have speculated that CMS will follow the same general approach as it did with the Medicare RAC program. If so, future regulations will proscribe, among other

practices in the region. Health care organizations and providers of all types—as well as state and national associations and professional societies active in health care policy issues—count on us to provide general and special counsel across a wide spectrum of issues. [Read More](#)

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things:

- the amount of records that the RACs may request;
- the amount of time providers have to respond;
- the permissible audit or "look-back" period; and
- the required reimbursement from the RAC to the provider for copying records.

For example, Medicare RACs may request only a certain number of records in a 45 day period, which varies based on provider type. Providers must respond to a Medicare RAC request for medical records within 45 days, unless an extension is granted. Medicare RACs are able to look back three years from the date the claim was paid, but are not permitted to review claims paid prior to October 1, 2007. Also, Medicare RACs are required to reimburse PPS providers and long term care providers 12¢ per page within 45 days of receiving the requested records.

Medicare RACs also must obtain CMS approval of each issue on which they plan to audit providers. In addition, they are authorized to use extrapolation. It is currently unknown whether these rules will be applied to the Medicaid RAC program. It is also unclear how Medicaid RACs will recoup overpayments from providers on behalf of the state. On November 10, 2010, CMS issued a proposed rule on the Medicaid RAC program, but the rule did not address these procedural issues. Since CMS expects states to fully implement their Medicaid RAC programs by April 1, 2011, CMS hopefully will release further guidance on these issues soon. In the absence of guidance, Medicaid RACs presumably will operate solely pursuant to the contractual terms in their individual agreements with states.

#### **MICs: Medicaid Integrity Contractors**

Background. The Deficit Reduction Act of 2005 required CMS to contract with MICs to audit Medicaid claims nationwide and identify improper payments. Although the MIC rollout has been slow, MICs are currently operating in almost half of the states. The Department of Health and Human Services reported that by the end of the 2009 fiscal year, MICs identified an estimated \$8.5 million in overpayments.

The goal of the MIC audits are to ensure that Medicaid claims are paid only for services that are provided and properly documented; for services that are billed using appropriate procedure codes; for services that are covered by the Medicaid program; and for services that are provided in accordance with federal and state laws, regulations, and policies. There are three types of MICs:

- (1) Review of Provider MICs (Review MICs), which analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities and identify providers that should be audited and issues on which auditors should focus;
- (2) Audit of Provider and Identification of Overpayment MICs (Audit MICs), which conduct post-payment audits of all

Medicaid provider types and identify overpayments; and

- (3) Education MICs, which develop training materials to conduct provider education and training on payment integrity and quality of care issues.

Audit MICs are not paid on a contingency fee basis and identify only overpayments; the actual recoupment of the funds remains the state's responsibility.

Procedures. There are no federal statutes or regulations regulating how MICs must audit providers. Although CMS published MIC policies this past September in order to make the program more consistent nationwide, it is unclear how, or if, the policies will be enforced.<sup>11</sup>

According to CMS, the Audit MICs, relying on data analysis performed by other CMS contractors, such as Review MICs, may perform desk audits or field audits of Medicaid claims, or a combination of both. Before beginning an audit, the state reviews and verifies the validity of data used by the Review MIC as the basis for the audit. Following the state's review and verification, the Audit MICs may request documents, conduct interviews, and tour facilities as part of the audit process. CMS policies provide that prior to the start of the audit, the Audit MIC must mail a notification letter to the provider that requests records and contains information on how the audit will proceed.

CMS policy now requires MICs to give providers thirty business days to produce records, with a possible fifteen day extension. Also, according to CMS, Audit MICs are now limited to a five year audit look-back period, beginning on the date of issuance of the notification letter to the provider. However, CMS stated that it retains the right to adjust the five year look-back period.

There are currently no limits on the number of records that a MIC may request nor is there any requirement that the MIC reimburse the provider for the cost of copying the records. Audit MICs are permitted to use extrapolation; however, in its recent Open Door Forum, CMS stated that MICs have not used extrapolation yet, but that CMS is considering its use in the future.

After it completes its review, the MIC must review its findings with the provider at an exit conference. Whereas the Connecticut Department of Social Services' (the "Department's") Medicaid audit process gives providers multiple opportunities to provide additional documentation, it appears that the exit conference is the only chance providers will have to provide the MIC with further information. In addition, while the Department's Medicaid audit process often engages the provider in a detailed review of the audit's findings, the MIC Audit exit conference will likely not be as collaborative and, in fact, need not even be an in-person meeting.

The MIC then prepares a draft report of its conclusions, which is approved by CMS and then provided to the state and the provider for comments. After considering all comments, the MIC prepares a revised draft report, which it submits to the state for additional review. After considering any additional comments from the state, CMS then finalizes the report, identifies the final overpayment amount, and

sends the final report to the state. The state is responsible for sending the final report to the provider and collecting the identified overpayment. When the Department performs Medicaid audits, it often agrees to a pay-back schedule, especially for large overpayments, and in certain circumstances may stay recoupment for a time after issuing the final audit report. However, it is unclear whether Connecticut will proceed similarly in regard to recouping overpayments identified by the MICs.

### **Open Questions**

Appeal Procedures. Both Medicaid RAC and MIC determinations are appealable. PPACA requires each state to establish an appeal process enabling providers to challenge the Medicaid RACs findings. CMS stated that it will not require states to adopt a new infrastructure to conduct Medicaid RAC appeals, so long as the state's existing appeal process can accommodate Medicaid RAC appeals. Connecticut has not yet formally announced what the Medicaid RAC appeal process in the state will entail, but it is quite possible that the Department will look to the current Medicaid audit process under Connecticut General Statutes § 17b-99 to serve as the Medicaid RAC appeal process. CMS requires that states submit a proposal describing the appeals process to CMS prior to implementing their Medicaid RAC programs.

In regard to MICs, CMS stated that, "providers may exercise whatever appeal or adjudication rights are available under State law when the State seeks to collect the overpayment amount identified in the final audit report." As with the Medicaid RAC appeal process, it is unclear what this appeal process will entail in Connecticut.

Interpretation of Connecticut Medicaid Rules. Since Medicaid RACs and MICs are independent auditors, they may not be well-versed with the state Medicaid rules, which in some cases are intricate and in other cases are unclear or lack detail. Medicaid rules also differ from state to state. Medicaid RACs will be responsible for recouping identified overpayments, but the extent to which they will be required to collaborate with the state on their findings is still unknown. However, since Medicaid RACs will be contracting with the state, the contract could include contractual audit process requirements. MICs, on the other hand, contract directly with CMS. States are given an opportunity to comment on the MIC's audit report, but there is no requirement that the state approve the MIC's findings. In fact, CMS said that although it "always strives to reach consensus with the State," it will not follow state policy that conflicts with CMS policy.

The potential for divergent interpretations of Medicaid reimbursement rules by the Department and CMS, and the resulting confusion for providers, is disconcerting. Also, when providers appeal the MIC and Medicaid RAC auditors' final determinations, it is unclear whether Connecticut courts will recognize the Department's interpretation of Medicaid rules or CMS's interpretation. Since both the Medicaid RAC and MIC appeal processes are to be governed by state law and handled by the state, neither CMS, the RAC, nor the MIC will be a party to the proceedings. It is unclear how the Department will position itself in the appeals process *vis-à-vis* the federal auditors' and/or CMS's audit conclusions. The answers to these currently

unanswered questions may have a significant impact on providers' appeals strategies.

Duplicate Audits. While the addition of the Medicaid RACs and MICs will certainly result in the review of more Medicaid claims, according to CMS, providers should not be subjected to duplicate audits. CMS stated that Medicaid RACs must coordinate their audits with other entities in order to avoid overlapping audits. CMS also stated that prior to the commencement of a MIC audit, CMS "vets" the provider with "partners and stakeholders in the State," including State Medicaid Agencies, state and federal law enforcement officials, and even Medicare contractors. If CMS discovers that another entity is conducting an audit or investigation of the provider, it "may cancel or postpone the Audit MIC audit of the provider."

CMS is expected to issue supplemental guidance in the future regarding the interface between Medicaid RACs and MICs. However, there currently is uncertainty regarding how these entities will coordinate their efforts with each other and with other auditors. It is important to emphasize that Medicaid RACs and MICs are only two of the numerous federal government contracted auditors, including, not only the Department and Medicare RACs, but also, Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs), which are tasked with detecting and investigating more serious allegations of Medicare fraud and abuse; Medicaid Fraud Control Units (MCFUs), which are responsible for the investigation and prosecution of health care providers who defraud the Medicaid program; and Fiscal Intermediaries (FIs), carriers, and Medicare Administrative Contractors (MACs), which are tasked with administering the Medicare program and ensuring that payment is made only where medically necessary and appropriate. Given the myriad of auditors reviewing claims, ensuring that providers are not subject to duplicate audits will be a daunting task.

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Providers should take the following steps to ensure that they are prepared for MIC and Medicaid RAC audits:

- Ensure that you have a standardized system in place for rapidly and accurately responding to audit requests, including producing records.
- Select a point person to be the main contact for communication with the auditor and educate employees not to speak to auditors without first notifying that point person.
- Keep apprised of the newest developments and stay educated about your appeal rights and limitations on the scope of the auditors' authority.
- Notify legal counsel early on that an audit is scheduled or underway, so steps can be taken, if necessary, to develop an appropriate "record" for appeal.
- Maintain documentation of all communication with the auditor, including copies of all of the records that were provided. These will prove invaluable should you decide to appeal the auditor's final determination.
- Strengthen your compliance program and independently audit your vulnerabilities so that you can deal with any billing issues

before they are identified by a government auditor.

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<sup>[1]</sup> These policies are available at: **Provider Audits Website;**  
**Medicaid Integrity Program A to Z** and **CMS: CPI-Informational**  
**Bulletin.**

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