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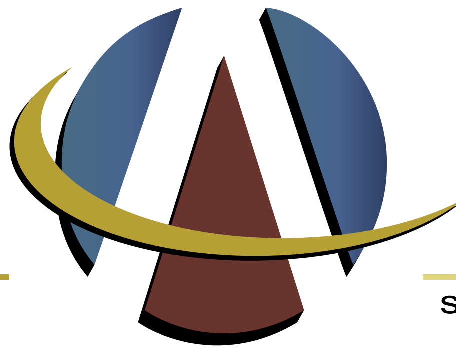

special investigation unit

2009, III VI

The Investigator

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Have a Story Idea? Questions?

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Surviving the MICs: Audit Fundamentals

The Medicaid Integrity Program (MIP) was created soon after the Deficit Reduction Act of 2005 was passed, introducing a new kind of audit program. This program requires the Centers for Medicare & Medicaid Services (CMS) to audit claims, review providers, identify overpayments and educate organizations in order to address specific issues in the Medicaid arena.

All US states are now participating in the Medicaid Audit program – as a result, all Medicaid delegated entities could be subject to an audit. This leaves little time for organizations to prepare and few are educated on the details of the MIC process.

Types of MIC Audits

There are three types of Medicaid Integrity Contractors (MICs): Review, Audit and Education. Review MICs (RMIC) analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities and identify Medicaid providers to be audited for the Audit MICs. Audit MICs (AMIC) conduct post-payment audits and identify overpayments for all types of Medicaid providers. Working with Review and Audit MICs, Education MICs (EMIC) educate health care providers, state Medicaid officials and others about a variety of Medicaid program integrity issues.

To conduct the audits, CMS has delegated MICs to review medical claims and identify instances of fraud, waste, abuse and overpayments. MICs will also be conducting provider claim audits and organization-wide education to promote integrity within health care claim payments and quality of care.

This may conjure up memories of the RAC audits which have been in the headlines over the past few years. However, the MIC audits are nothing like the RACs.

The purpose of the RACs was to determine whether RAC audits would be an efficient and cost-effective tool in identifying overpayments, under-payments and returning dollars to CMS. As a result, many of the RAC auditors identified high-dollar claims that were paid based on medical necessity and are now facing lawsuits.

Alternately, MIC auditors are meant to assure that claims are paid in accordance with the specific services provided and documented. Additionally, the MICs will verify that appropriate procedure codes and covered items and services are provided and paid according to federal and state regulations, policies and laws. If executed correctly, these audits will verify the accuracy of medical claim payments – and the federal government will demand recoupment within 60 days of the audit.

Preparing for the MIC Audits

The most important thing a payer, state or provider can do to protect itself is to understand the issues that may arise during an audit through their own proactive audit and to address those issues before the MIC identifies them. Once issues are identified, including overpayments, recouping those dollars and putting them into an interest-bearing account, will ensure the funds are available when the MIC conducts its audit.

▪ Continued on page 2

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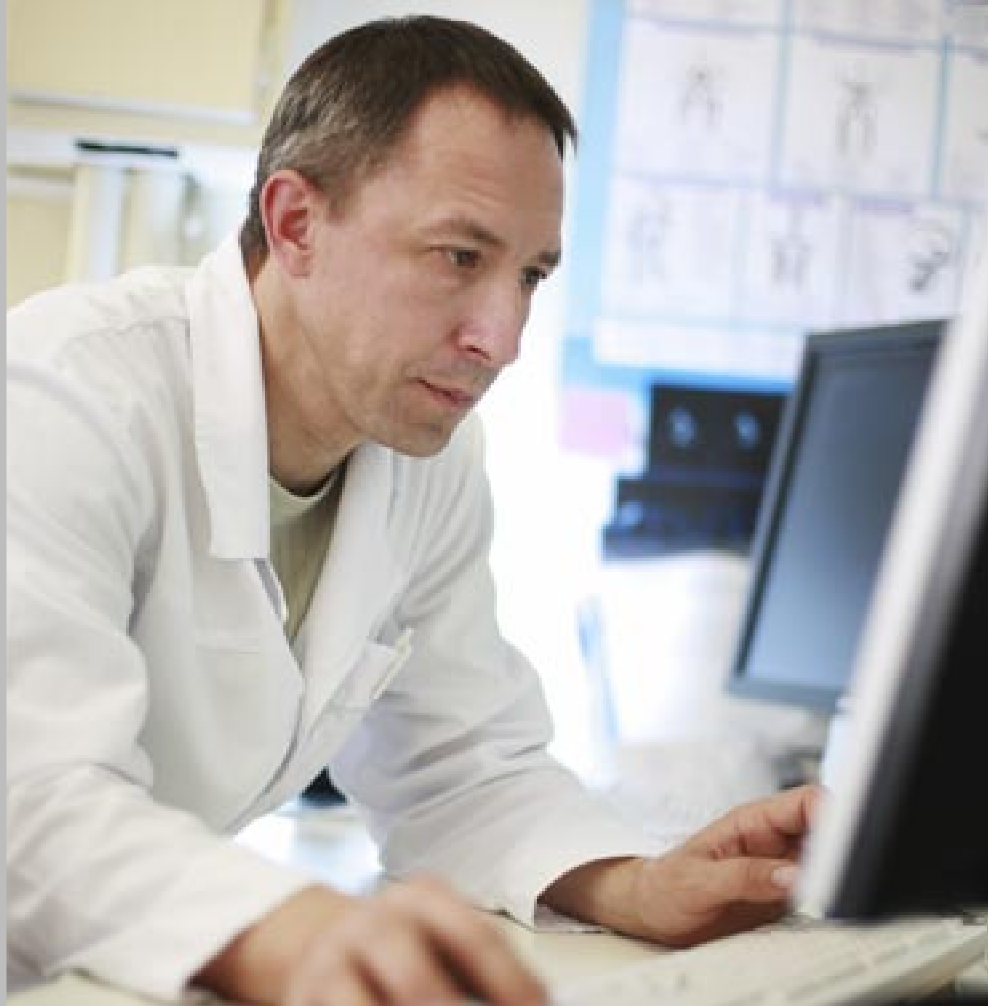
Unlike other audits in the past, the MICs are mandated to verify that claims follow state and federal regulations; which is why it is very important that when a provider, payer or state conducts a self-audit, they apply state-specific edits. This will enable a much more accurate identification of issues before the audit.

When conducting the pre-audit, source documents should be requested internally and verified that the procedures and services that are documented, performed and billed are the same. Additionally, it is important to verify that all applicable federal and state laws, regulations and policies are being followed before coordinating and tracking for recovery.

Although the MIC audits can seem intimidating and ominous, taking the necessary steps to prepare your organization for the inevitable will help make the process much smoother. The most important thing is to educate and prepare your organization and know what to expect from the MICs.



Feature	MIC	RAC
Applicable Laws	Federal and State	Federal
Days Required to Produce Medical Records	Dependent on State Rules	45 Calendar Days
Compensation Tied to Recovered Dollars	No	Yes
Scope of Audit	Fee for Service Providers, Institutions & Non-Institutions as well as Managed Care Entities	Physicians, Providers and Suppliers who Submit Claims for Medicare Parts A & B
Look-Back Period	Unlimited	3 Years No earlier than 10/1/07
Medical Request Limits	None	Up to 200
Auditor Payment Method	Fee-for-Service Model	Contingency Fee
Copy Reimbursement from CMS	No	Yes
Re-Payment to CMS	60 Days, No Appeal Process, Paid in Full	Appeal Process and Payment Plans
Types of Audits Performed	Desk Audits, On-Site Audit Reviews	Automated Review, Complex Review

MIC vs. RAC
MIC audits are often mistakenly compared to the RAC (Recovery Audit Contractor) audits. However, there are vast differences between the two types of audits as illustrated in the chart above.

Provider Education: Modifier 25

There is virtually no such thing as standard Medical Services: the provided care each person receives is specific to their own needs.

Medical billing, however is supposed to be standard. Medical billers use American Medical Association's (AMA) CPT codes to account for medical services. As you can imagine, sometimes a CPT codes doesn't quite capture exactly what occurred, and it's the billers' responsibility to use a modifier. Modifiers are used when the CPT code is still accurate – the definition and code are the same – but the service had to be altered for a specific reason to help fit the services that were rendered.

That being said, it's not always understood how to use modifiers accurately and as a result – there is a high occurrence of fraud, waste, abuse and errors for modifier usage.

Modifier 25 is one of the mostly highly abused modifiers for CMS. According to CMS, approximately 35% of Medicare claims using Modifier 25 don't meet program requirements for the year 2002.[1]

Why does this happen? There is some confusion as to what exactly qualifies under Modifier 25.

According to the AMA CPT, Modifier 25 is used when there is a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service."

The problem most providers have in this area is determining what is a significant, separately identifiable service – what makes a significant service? Is it time? How much the procedure costs? The physical impact on the patient? No – what makes a service separate and significant is if it can fulfill the requirements for an E&M service on its own.

This means for every service that a provider uses Modifier 25, it must be documented on that level. Because this is such a big area for fraud, providers using Modifier 25 should be aware that their service has a significantly higher chance of being reviewed and should take care to document properly, and when in doubt – over document.

Documentation on the service should include the patients' history, exam and medical decision making. For a detailed explanation, refer to AMG-SIU's whitepaper, How to Correctly Document an Established Patient Claim.

Another big problem providers' encounter with Modifier 25 is knowing what CMS means by the same provider? A provider means a physician/nurse/etc. that is in the same group and provides the same specialty.

Without Modifier 25, the second service or procedure to the same group and specialty on the same day would probably be denied. Advanced algorithms, logic and sophisticated editing systems identify when Modifier 25 is being used incorrectly and will trigger an alert to the payer.

The other common issue with Modifier 25 surrounds new patients – can you use Modifier 25 automatically when you have a new patient? No, you can't. Sometimes providers think that seeing a new patient and performing the background and a thorough physical should be considered separate from whatever procedure the patient was seeking– but that's not the case.

New patients follow the same guidelines as established patients for Modifier 25. If the patient has a significant and separately identifiable service that would fulfill the requirements for an E&M service in addition to a procedure or other service on a new patient, then that service would qualify for Modifier 25.

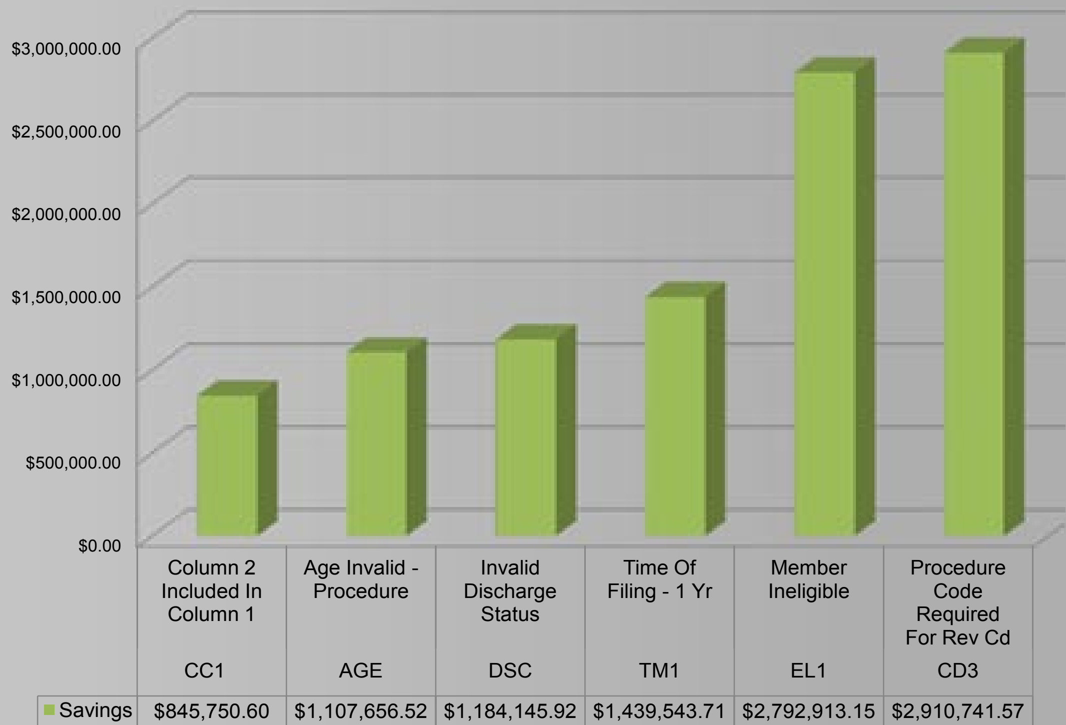
[1]*Department of Health and Human Services, Office of the Inspector General "Use of Modifier 25", Daniel R. Levinson Inspector General, November 2005*

Dollar Savings for Common Edits
During 3rd Quarter 2009

One of the reasons AMG-SIU is so different from other fraud, waste and abuse detection companies is the amount of detail we put into our work. AMG-SIU has hundreds of categories of edits with thousands of edits in each category.

So you may be thinking, with all of these edits at work finding potential fraud, waste, abuse and errors in client data which ones are common across all of our clients?

To the right is a graph depicting the most common edits that AMG-SIU identified for its clients during the 3rd Quarter of 2009, along with thte savings that were detected.



	Column 2 Included In Column 1 CC1	Age Invalid - Procedure AGE	Invalid Discharge Status DSC	Time Of Filing - 1 Yr TM1	Member Ineligible EL1	Procedure Code Required For Rev Cd CD3
Savings	$845,750.60	$1,107,656.52	$1,184,145.92	$1,439,543.71	$2,792,913.15	$2,910,741.57

10 Steps in a MIC Audit

1. Identify Potential Audit Areas Through Data Analysis
2. Confirm Audit Targets with the State: Verify MIC Auditors are Not Duplicating State Efforts
3. Audit MIC (AMIC) Receives Audit Assignments
4. AMIC Schedules An Entrance Conference:
   a. Providers receive notice at least 2 weeks before the audit begins
   b. Record request enclosed with notice: 15 days min. given for small claims volume, 45 days for large claims volume
   c. Records are sent to AMIC or made ready for a field audit
   d. Entrance conference is either in-person or telephonically
5. AMIC Performs Audit:
   a. Most audits are desk audits
   b. Field audits are conducted at the provider site
   c. Audits are conducted according to Generally Accepted Government Auditing Standards (GAGAS)
6. Exit Conference:
   a. AMIC holds exit conference with the provider to discuss preliminary findings
   b. Provider can comment on preliminary findings and provide more information
   c. If potential overpayment is found, AMIC prepares a draft audit report
7. Review Draft Audit Report:
   a. Draft audit is given to CMS for approval and to the State for review
   b. Report is given to the provider for review
8. Final Audit Report:
   a. If a state's interpretation of a policy conflicts with CMS, CMS has the final authority to make determination
9. CMS Issues Final Report To State:
   a. State must repay federal share of overpayment within 60 days
10. State Issues Final Audit Report to Provider & Begins Overpayment
    a. Recovery