Michigan Department of Health and Human Services
Office of Inspector General

POST PAYMENT AUDIT PROCESS

Complex Audit (audits that <u>require</u> records to be reviewed):

- Medical Record Request letter is sent to provider's correspondence address.
- Provider has 30 calendar days to respond to request.
    - If no records are submitted, a Final Notice of Recovery will be issued, and the provider has 30 calendar days to request an Appeal, or MDHHS will initiate recoupment activities. (See Appeal Process below)
- When records are submitted, CoventBridge typically has 180 days to conduct the audit and issue a Draft Findings Report.
- Provider has 30 calendar days to respond to the draft findings. They can agree with the findings or submit rebuttal documentation to CoventBridge for reconsideration. (See Rebuttal Process below)
- The provider has 30 calendar days to submit rebuttal documentation. If rebuttal documentation is not sent, the preliminary findings become final. A Final Notice of Recovery will be sent to the provider.
- Provider has 30 calendar days to agree with the Final Notice and complete the recoupment instructions provided in the Final Notice of Recovery or request an appeal. (See Appeal Process below)
- If the provider does not appeal the Final Notice of Recovery and does not complete the recoupment instructions provided in the Final Notice of Recovery within 30 calendar days, MDHHS will initiate recoupment activities.

Automated Audit (audit that <u>does not</u> require records to be reviewed):

- A Draft Findings Report is sent to provider.
- Provider has 30 calendar days to respond to the draft findings report. Providers may agree with the findings or submit rebuttal documentation to CoventBridge for reconsideration. (See Rebuttal Process below)
- The provider has 30 calendar days to submit rebuttal documentation. If rebuttal documentation is not sent, the preliminary findings become final. A Final Notice of Recovery will be sent to provider.
- Provider has 30 calendar days to agree with the Final Notice and complete the recoupment instructions provided in the Final Notice of Recovery or request an appeal. (See Appeal Process below)
    - If provider does not appeal the Final Notice of Recovery and does not complete the recoupment instructions provided in the Final Notice of Recovery within 30 calendar days, MDHHS will initiate recoupment activities.

Rebuttal Process:

- When a provider disagrees with the draft findings from CoventBridge, they may submit rebuttal documentation for reconsideration within 30 calendar days of the date of the draft findings report.
- Once the rebuttal documentation has been reviewed, a Final Notice of Recovery will be issued to the provider.
- A Provider has 30 calendar days to agree with the Final Notice and complete the recoupment instructions provided in the Final Notice of Recovery or request an appeal. (See Appeal Process below)
- If the provider does not appeal the Final Notice of Recovery and does not complete the recoupment instructions provided in the Final Notice of Recovery within 30 calendar days, MDHHS will initiate recoupment activities.

Appeal Process:

A Provider has the right to appeal any decisions by requesting an Internal Conference, or an Administrative Hearing as set forth in the 1979 Administrative Code R.400.3401 et seq. Providers must request their appeal, in writing, within 30 calendar days of the notice of adverse action (i.e., Final Notice of Recovery). If a provider does not submit a request for an appeal within 30 calendar days of the Final Notice of Recovery, the notice of adverse action is final, and the department will initiate recoupment activities.

Internal Conference

- The purpose of the internal conference is to determine whether the department action was taken according to MSA policy.
- Requests for an internal conference must be in writing and made within 30 calendar days of the adverse action (i.e. Final Notice of Recovery). Internal Conferences will be heard by an appeal review officer.
- The appeal review officer may deny requests for internal conferences that are not received within the timeframe specified in the notice of adverse action.
- All appeal requests must include all the following items:

  (a) A copy of the Final Notice of Recovery received.
  (b) A list of all items being appealed.
  (c) The dollar amount involved, if any.
  (d) All necessary documentation to support the reason for the internal conference.

Failure to follow these requirements may result in the denial of the internal conference by the appeal review officer.

Should the provider and/or MDHHS disagree with the internal conference decision, either party has the right to an administrative hearing.

Administrative Hearing

- Requests for an administrative hearing must be in writing and made within 30 calendar days of the adverse action (i.e. Final Notice of Recovery) or the internal conference decision.
- All appeal requests must include all the following:
  - (a) A copy of the Final Notice of Recovery or Internal Conference decision received.
  - (b) Specifically outline/identify the aspects of determination with which you disagree
  - (c) Explain the reason(s) why the provider believes the determination on those matters is incorrect.
  - (d) The dollar amount (if any) involved
  - (e) Documentary evidence to support your position and reasoning

If the conference/hearing results in an overturn decision, the Office of Inspector General (OIG) will issue a Final Notice of Appeal Overturn and cease recovery; no further action will be required by the provider.

If the conference/hearing results in an upheld or amended decision, OIG will issue a Revised Final Notice and the provider has 30 calendar days to complete the recoupment instructions provided in the notice. If the provider does not complete the recoupment instructions provided in the final notice within 30 calendar days , MDHHS will initiate recoupment activities.

Additional information regarding the MDHHS Appeals process can be found in the General Information for Providers Chapter of the Michigan Medicaid Provider Manual and in the Michigan Administrative Code (1979 Administrative Code R.400.3401 et seq). Appeal Department contact information can be found in the Medicaid Provider Manual Directory Appendix.

Post Payment Audits

FREQUENTLY ASKED QUESTIONS

1. **What is the look back period for the audits?**

   The lookback period will typically include claims with a date of service beginning 10/01/2014 or later.

2. **What provider types should be prepared for audit?**

   All provider types are subject to post payment auditing.

3. **What types of audits will be performed?**

   Automated Reviews – Used when improper payments can be identified from claim data elements and well-established policies and rules, without examining medical records or other documents.

   Complex Reviews – Used when the review requires the examination of medical records or other documents.

4. **Will these audits review Fee-For-Service (FFS) claims and Managed Care/encounter (ENC) claims?**

   Currently, only Fee-For-Service claims are being reviewed with these audits.

5. **Will Medicare or commercial primary claims be included in post payment audits?**

   No.

6. **Can I submit records electronically?**

   Yes. CoventBridge will also accept provider submissions of electronic records on CD/DVD, secure transmission, SFTP, United States Postal mail or FedEx (hard copy documents or password protected CD\DVD). Please refer to your record request/engagement letter for additional details.

7. **How long do I have to respond to a review?**

   Providers have 30 calendar days from the date of the letter to respond to CoventBridge's request for records.

8. **How long does CoventBridge have to audit after the medical records request letter is sent?**

   CoventBridge will typically provide a Draft Findings Report within 180 days of requesting medical records for review.

9. **Will extensions be allowed if delays occur in obtaining documentation needed?**

   If a provider requires an extension, they may submit a request in writing to CoventBridge prior to the deadline provided in the record request letter. All extension requests will be granted at the sole discretion of the Michigan Department of Health and Human Services Office of the Inspector General (MDHHS OIG).

10. **After I have received CoventBridge's Draft Findings Report, may I ask for an additional review?**

    Yes. Providers will have 30 calendar days to submit rebuttal documentation to CoventBridge. Providers will be encouraged to provide additional documentation that is relevant to the finding to support their assertion of correct payment.

11. **Will I have an opportunity to respond to the Final Notice Report?**

    Yes. Providers will have 30 calendar days to request an appeal in response to MDHHS OIG's Final Notice Report.

12. **What happens if I disagree with the Final Notice Report?**

    The provider has the right to appeal the Final Notice Report through standard MDHHS appeal processes. Appeal right notification and instruction may be found on the Final Notice of Recovery.

13. **If I appeal the Final Notice Report and request an administrative hearing or an internal conference, will I still have to pay back the amount of the overpayment in the Final Notice Report?**

    If the provider submits a timely request for an administrative hearing or an internal conference, no recovery of the identified claim will occur until the appeal is resolved.

14. **What happens if I fail to respond to an audit?**

    Failure to respond to an audit within the timeframe identified in the notice may result in the recovery of all claims for which a response was not received. Providers will be notified prior to any recovery actions occurring.

15. How does CoventBridge determine if a provider's paid claim is an overpayment?

CoventBridge uses Michigan Medicaid MSA policy, legislation and Michigan Medicaid claims data to determine if a paid claim is an overpayment.

16. Will CoventBridge identify underpayments?

No.

17. Will extrapolation be applied to determine the amount of the overpayments?

Statistical sampling and extrapolation may be used in the audit.

18. How will overpayments be recouped?

Claims Adjudicated in CHAMPS -The preferred method of recovery for a claims-based (i.e., probing audit), post-payment audit is the providers electronic adjustment of their claims. When in agreement with the findings, providers may initiate an adjustment of the claims in question via CHAMPS.

- Providers must include 'DHHS-OIG-UPIC' in the comments field of the adjusted claim. Claim adjustments submitted with this comment are monitored.
- Claims not adjusted by the provider within the time frame identified will be voided or gross adjusted by MDHHS.
- For sampling and extrapolation audits, MDHHS OIG will initiate collection via a gross adjustment of the overpayment amount via CHAMPS. The gross adjustment will be applied to future claim submissions.
- Providers are expected to follow the Recoupment Instructions provided in their final notice (i.e., Final Notice of Recovery or Final Notice of Appeal Decision).
- Failure to respond within 30 calendar days to the Final Notice of Recovery will result in MDHHS OIG initiating recoupment of the overpayment amount identified in the Final Notice of Recovery.

Pharmacy Claims Adjudicated in Magellan's Point of Sale System - When in agreement with the findings, providers may initiate repayment by submitting a check to MDHHS.

- Providers will be required to submit a check to MDHHS for the full overpayment amount.
- Providers are expected to follow the Recoupment Instructions provided in their final notice (i.e., Final Notice of Recovery or Final Notice of Appeal Decision).
- Any administrative errors that were subsequently validated by prescriber medical records may incur a partial overpayment in the amount of the claim's dispensing fee. Patterns may be referred to MDHHS as a FWA referral.
- Failure to respond within 30 calendar days to the Final Notice of Recovery will result in MDHHS OIG initiating recoupment of the overpayment amount identified in the Final Notice of Recovery.

Home Help Payments made via ASAP/MiAIMS - When in agreement with the findings, providers may initiate repayment by contacting MDHHS OIG.

- MDHHS OIG will initiate collection via a gross adjustment of the overpayment amount.
- Providers will be required to submit a check to MDHHS for the full overpayment amount.
- Providers are expected to follow the Recoupment Instructions provided in their final notice (i.e., Final Notice of Recovery or Final Notice of Appeal Decision).
- Failure to respond within 30 calendar days to the Final Notice of Recovery will result in MDHHS OIG initiating recoupment of the overpayment amount identified in the Final Notice of Recovery.

19. If a claim is not available for adjustment by the provider, how does a provider manage their claim for correction?

Claims Adjudicated in CHAMPS -

- If the claim is no longer in CHAMPS, providers should contact the MDHHS OIG analyst indicated in their Final Notice of Recovery.
    - MDHHS OIG will initiate collection via a gross adjustment of the overpayment amount.
- Claims that are beyond the timely filing limit should be submitted as an adjustment (replacement) claim.
- Providers must add “MDHHS-OIG-UPIC” in the comments/notes field as the reason for the adjustment/void.
- Providers must submit all adjustments/voids prior to the end of the 30-day time frame indicated in their Final Notice of Recovery.
    - The new claim can be submitted after the void claim has been issued to a Remittance Advice and must include ‘DHHS-OIG-UPIC’ in the comments field.
- Providers needing assistance in adjusting or voiding claims in CHAMPS may contact MDHHS Provider Support at 1-800-292-2550.
- Failure to respond within 30 calendar days to the Final Notice of Recovery will result in MDHHS OIG initiating recoupment of the overpayment amount identified in the Final Notice of Recovery.

20. Is there a limit to the number of records CoventBridge can request?

The records requested by CoventBridge shall not exceed 150 records, per request, or 500 in a three-month period, by billing NPI.

21. Will providers be reimbursed for sending medical records?

No. Pursuant to Michigan Department of Health and Human Services Medicaid Provider Manual, General Information for Providers Chapter, Section 15.4 Availability of Records, "Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained. Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid." CoventBridge is a MDHHS authorized agent that routinely requests medical and other records to ensure proper compliance with Michigan Medicaid Program rules, regulations, policies, and procedures. These records are used to ensure full and proper compliance with Michigan law, Michigan Medicaid policy and to ensure that proper payments have been made to the Provider. Please be advised that the cost of providing records is considered a cost of doing business and is not separately reimbursable to providers by the State of Michigan.

CoventBridge will also accept provider submissions of electronic records on CD/DVD, secure transmission, SFTP, United States Postal mail or FedEx (hard copy documents or password protected CD\DVD). Please refer to your record request/engagement letter for additional details.

Resources

- CHAMPS Webpage
- Michigan Medicaid Provider Manual