

**MEDICAID INTEGRITY CONTRACTORS: THE NEXT BIG WAVE**



**Medicaid claims increasingly are becoming a target of government scrutiny due in large part to the implementation of the Medicaid Integrity Program (MIP).**

With this increasing focus, providers now need to prepare for audits of Medicaid claims in addition to their work to ready themselves for Medicare audit initiatives such as Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs). The MIP program is the federal government's first attempt to audit state-run Medicaid programs directly. Historically, Medicaid claims have received little government scrutiny, often resulting in a high error rate. Through the MIP, the federal government now is combating fraud and abuse in state-run Medicaid programs directly. The

MIP requires CMS to contract with Medicaid Integrity Contractors (MICs) to provide anti-fraud education to Medicaid providers and to identify overpayments by conducting post-payment audits of Medicaid claims .

There are three types of MICs – Education MICs, Review MICs and Audit MICs – and each has a different role. Education MICs are responsible for educating providers, beneficiaries and others on program integrity and quality-of-care issues. Review MICs analyze Medicaid providers' claims data for evidence of atypical billing practices that could result in overpayments. Audit MICs conduct post-payment audits of Medicaid providers. The Audit MICs determine which providers to audit in part based on leads received from CMS, state

agencies or the Review MICs. CMS has divided the country into five MIC jurisdictions, each of which encompasses two CMS regions. Contracts for Education MICs, Review MICs and Audit MICs are awarded separately for each of the five MIC jurisdictions, and CMS has awarded contracts and assigned task orders to the various MIC contractors on a staggered basis, beginning in April 2008. The Audit MICs have commenced audits of Medicaid providers in most jurisdictions, and audits are anticipated to begin in the remaining jurisdictions by June 2010. This past summer, CMS indicated that Audit MICs were performing nearly 500 audits on a variety of providers, including hospitals, long-term care facilities, physician practices, transportation services and laboratories.

**Continued on pg. 3— Medicaid Integrity Contractors..**

**QUOTE OF THE MONTH...**

**“ The greatest thing in this world is not so much where we are, but in what direction we are moving.”**

**O.W. Holmes**

**CONSIDER SOME LESSONS TOYOTA CAN LEARN FROM HEALTHCARE**

For decades, those of us involved in improving patient safety looked to Toyota Motor Corp. for guidance and inspiration in improving quality in healthcare. The Toyota Production System has been touted as the key to error reduction and consistency in product quality. The quest to

build a “Toyota of healthcare” has been the mantra for many in medicine, spawning teams of healthcare executives on field trips to Japan and consulting groups touting the car company's “lean” industrial processes for healthcare.

The key to The Toyota

Production System has been employee engagement in failure identification and empowerment to participate in continuous improvement. Toyota's performance improvement methods have

**Continued on pg. 4— Toyota can learn from healthcare...**

## HOUSE ACTS TO CLOSE 72 HOUR LOOP

In legislation that effectively ends the debate on whether hospitals can unbundle and bill any outpatient services that were provided within 72 hours of an admission, The American Jobs and Closing Tax Loopholes Act was introduced to the House of Representatives as an amendment to the Senate's American Workers, State and Business Relief Act.

The House Bill includes language that would prohibit hospitals from billing separately for "other services related to an admission" within a 3 day or 1 day

window for acute care hospitals and critical access hospitals, respectively. When billing for any outpatient services within this timeframe, it would be up to the hospital to prove that the service was unrelated in a manner to be "determined by the Secretary." Further, the Act prohibits any rebilling of past cases based on this issue.

This Bill will apparently have no impact on RACs' ability to unbundle outpatient services from inpatient services in their efforts to recoup overpayments, particularly for

surgical cases where admissions were the result of complications that occurred during surgery or recovery. The elimination of the 72 Hour Rule "loophole" is just one point in this bill that establishes or extends many popular programs (including a recent COBRA revision.) Look for it to pass quickly and without much debate. The full text of the bill can be found at <http://waysandmeans.house.gov/press/PRArticle.aspx?NewsID=11185>. The Clarification of the 3-Day Payment Window is found on page 364 of the legislative text.

RAC ALERT: Written by Dennis Jones

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## EFFECTIVE MANAGEMENT

Developing effective management skills to deal with specific challenges and problems of each organization is the urgent needs of many businesses and organizations in the global competitive environment, rapid changing of technology and environment. The new tendency of training and development of successful organizations over the world today is developing effective skills in dealing with specific challenge of their own organization to reach their own mission and objectives in the new organization that characterized by networked, flat, flexible, diverse, global organization.

"Effective Management Skills" to help people and organization improving their own effectiveness and

efficiency. Globalization and rapidly developing technology shows we are in a period of intense competition. Proper management is vital in these complex environments. The quality of manager and effective management styles can determine the culture of the organization, the productivity of its staff, and, ultimately, success or failure. A manager should have the ability to direct, supervise, encourage, inspire, and coordinate, and in doing so facilitate action and guide change. Managers develop their own leadership qualities and those of others. Management utilizes planning, organizational and communications skills. These skills are important in leadership also, but even more so are qualities such as integrity,

honesty, courage, commitment, sincerity, passion, determination, compassion and sensitivity.

An effective manager should have the following skills.



Creative Problem Solving Skills: (1) Describing and analyzing a problem, (2) Identifying causes of a problem, (3) Developing creative options and choosing the best course of action, and (4) Implementing and evaluating effective and efficiency of the decision.

Communication Skills: (1) Listening skills, (2) Presentation skills, (3) Feedback Skills, (4) Report writing skills.

Conflict Management Skills: (1) Identifying sources of conflict functional and dysfunctional conflicts, (2) Understanding personal style of conflict resolution, (3) Choosing the best strategy for dealing with a conflict, and (4) Developing skills in promoting constructive conflicts in organization and teams.

Negotiation Skills: (1) Distinguishing distributive and integrative negotiations, position and principle negotiation, (2) Identifying common mistakes in negotiation and ways to (3) avoid them, (3) Developing rational thinking in (4) negotiation, and (4) Developing effective skills in negotiation that benefits all parties involved.

Self-Awareness and Improvement: (1) Understanding the concept of self-management, (2) Evaluate the effectiveness of self-management, (3) Developing creative and holistic thinking, (4) Understanding the importance of emotions in works as well in self-development, (5) Understand of self motivation, and (6) Effectively managing self-learning and change.

by: Margaret Francis, MSW, M.Phil, PGDCIM

## MEDICAID INTEGRITY CONTRACTORS...CONTINUED FROM PAGE 1

### The MIC Audit Process

All Medicaid providers are subject to MIC audits. Although Audit MICs, unlike RACs, are not paid on a contingency fee basis, Audit MICs are eligible for financial bonuses based on the effectiveness of their audits.

Review MICs perform post-payment reviews of Medicaid claims and then recommend selected providers to be audited by the Audit MICs. CMS is responsible for ensuring that investigations or other audits of these providers for similar Medicaid issues are not already underway by state Medicaid agencies, state or federal law enforcement or Medicare contractors. If a provider is selected for an audit, an Audit MIC should notify a provider via letter of the specific claims and records to be reviewed prior to commencing an audit. Audit MICs can review Medicaid claims as far back as permitted under the laws of the respective states that have paid the claims. The Audit MICs also are not limited to a set number of claims for which they may request records, and the Audit MICs may request that records be produced in as little as two weeks.

An Audit MIC also may request that a provider produce the relevant records in specific formats, such as color or electronic copies, although Audit MICs do not have to reimburse providers for the cost of producing the records. If a provider has concerns about the records request, the audit or the production timeline, the provider should contact the

Audit MIC. Requests for time extensions generally are granted, as long as the extensions do not compromise the integrity or timeliness of the audit.

The Audit MIC also will contact the provider to schedule an entrance conference (in-person or via telephone) to describe the audit's scope and objectives. For most audits, the provider will send the requested records to the Audit MIC for a "desk audit" at the contractor's office. However, in some circumstances Audit MICs may conduct on-site audits at the provider's office. This type of audit is known as a "field audit."

After completing the audit, the Audit MIC will present preliminary findings to the provider at an exit conference, and the provider should have an opportunity to comment and to provide additional information. If the Audit MIC concludes that there is a potential overpayment to the provider, it will share a draft report with CMS for approval and with the state for review. The provider also should receive a copy of the report for review and comment.

Based on information provided by the state or the provider, the findings and any assessed overpayment may be adjusted before the audit report is finalized. However, CMS has the ultimate responsibility for determining the final overpayment in any audit. CMS will send the final audit report to the state, and the state then will have 60 calendar days to repay the federal share of the Medicaid overpayment to CMS

regardless of whether the state recovers, or seeks to recover, the overpayment from the provider. The state is responsible for issuing the final audit report to the provider in accordance with the state's administrative process for overpayment recovery.

In the event that the provider disputes the overpayment assessed in the final audit report, it may exercise applicable appeal or adjudication rights. Unlike other CMS audit contractors such as RACs and ZPICs, which must follow specific appeal processes set forth in federal regulations, providers' appeal rights under the MIP are determined by the laws of the respective states.

### Tips to Prepare for an Audit

- Develop policies and procedures in advance to generate timely response to audit requests. These policies and procedures should include the tracking of requests and responses, and designation of an internal point of contact to direct the audit.
- Verify that the appropriate individual is designated as the contact person with the state. A letter from the Audit MIC will be sent to the individual listed with the state as the provider's contact person. Thus, providers should contact the state to verify that the appropriate contact person is listed.

Continued on pg. 4— Medicaid Integrity Contractors..

## NATIONAL FLAG DAY

The National Flag of United States was being adopted on that day, thus, it is celebrated as the National Flag Day.

Adoption of Flag on that day took place in the year 1777 during the time of resolution taken on Second Continental Congress.

During 1916, President Woodrow Wilson established this day as an official National Flag Day.

Then again during 1949, Act of congress re-established National Flag Day on 14th June. Though Flag Day is neither a federal; holiday nor one

can declare it as an official leave.

But during 1937 on 14th June, Pennsylvania was the first and foremost states of U.S. who celebrated Flag Day as a state holiday.



## MEDICAID INTEGRITY CONTRACTORS...CONTINUED FROM PAGE 3

- Ensure that correspondence from an Audit MIC is directed to the appropriate internal point of contact. An Audit MIC letter may be addressed on the private contractor's letterhead rather than CMS, Medicaid or state letterhead. Providers should train personnel on how to identify Audit MIC letters and instruct staff to direct such letters to the internal point of contact as soon as they are received.
- Alert legal counsel when notice of an audit is received. Because MICs are looking for fraud and abuse, providers should consult with counsel to ensure that their rights are being protected. Legal counsel then can assist the provider in monitoring and documenting the audit process, protecting the provider's rights and ensuring that Audit MICs follow CMS and state guidelines.
- Provide complete records in a timely manner. Providers should keep track of all deadlines and ensure that records are submitted prior to them. Before submitting any records, providers should verify that all necessary records to support the audited claims are being provided. Providers also should maintain a copy of all documents provided to the Audit MIC.
- Learn the procedures for appealing unfavorable audit results. Providers should develop policies and procedures for appealing such results that take into account applicable state requirements. Because each state's appeals process will vary, providers operating in multiple states in particular should become familiar with each state's appeal process to ensure that appeals are made in a timely and

appropriate manner.

### Conclusion

By understanding the MIP audit process, providers can prepare for the arrival of Audit MICs to reduce the potential for disruption from an MIC audit. Providers should prepare in advance by maintaining strong compliance programs, which should include appropriate education and training on Medicaid billing practices as well as the performance of internal audits to ensure that Medicaid claims are being billed properly. If providers determine through these internal audits that mistakes were made in billing Medicaid claims, the providers should correct the mistakes and return any overpayments. Additionally, providers also should develop policies and procedures for responding to audits and appealing any negative audit results. Through effective internal reviews and audits, providers can ensure that they are billing Medicaid claims appropriately and minimizing the likelihood of being subject to MIP audits.

For additional information about the MIP, please see: <http://www.cms.hhs.gov/MedicaidIntegrityProgram/>.

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## TOYOTA CAN LEARN FROM HEALTHCARE...CONTINUED FROM PAGE 1

been adapted by dozens of U.S. hospitals and have been reported as being successful in improving outcomes and efficiency. Given Toyota's recent quality issues, these are tough days for admirers of the company.

Since the 1999 release of *To Err is Human*, the Institute of Medicine's report on the prevalence of preventable medical errors in hospitals, American healthcare has been pretty hard on itself. Recognizing its responsibility for allowing these errors to

occur, policymakers, researchers and healthcare leaders have been engaged in a number of important initiatives that have led to a safer environment for patients. Maybe it is now time for us to reciprocate and share some of what we've learned with Toyota.

When errors happen in hospitals, disclosure of the event to the patient and family is essential for effectively dealing with the problem. Hospital leaders have learned that failure to tell patients and families

what has occurred leads only to further problems and builds institutional barriers to creating safe cultures. We have also learned that when mistakes are made, apologies are an important part of the process; accountability and saying "I'm sorry" can help patients, families and caregivers in the healing process.

Dealing with errors is rarely easy. When Jessica Santillan—a 17-year-old being treated at Duke University Hospital, Durham, N.C.—died after being given the wrong heart and lungs, the hospital responded with a candid acknowledgement of the error and a sincere apology from her doctor—actions that diffused public outcry over a horrific situation and immediately helped rebuild trust with future patients.

Hospitals have worked in recent years to create new systems for the rapid identification of problems when they occur. Healthcare workers are encouraged to report both errors and

**Continued on pg. 5—Toyota can learn from healthcare...**

## TOYOTA CAN LEARN FROM HEALTHCARE...CONTINUED FROM PAGE 4

potential errors, using incident reports and other reporting systems. Medical staffs use peer-review processes to examine safety concerns or deviations from standard practices. Insurers have begun pay-for-performance systems that work with hospitals to monitor quality data and change payments based on improvements in quality data. Data on hospital quality is now increasingly reported to the public through government and private initiatives and is accessible on the Web through numerous commercial companies.

Toyota was slow to act in the face of its problems. The company first received reports of problems with its accelerator pedals in March 2007. On Aug. 28, 2008, a family was killed after the gas pedal got caught under the floor mat. On Sept. 26, 2009, Toyota first publicly revealed the potential

problems with its gas pedals. It announced a vehicle recall on Oct. 6, 2009, and expanded the recall on Jan. 21, 2010, but it was not until Jan. 26 that it suspended sales and production. Since then, Toyota has been working to mechanically fix what it believes may be causing these problems in their cars. No doubt Toyota has been working tirelessly to identify and fix the problem, but customers want to know that they are being dealt with honestly and openly.

In April, Toyota paid a record \$16.4 million fine to the National Highway Traffic Safety Administration for its slow response in the recall effort, and as of May 1 faced more than 320 lawsuits in federal and state court related to its sudden acceleration problems.

Toyota is paying a high price for its mistakes. Some estimate the direct cost in the billions. Most likely there will be additional economic damage as a result of deterioration in consumer confidence in the brand. Yet despite what can be seen

only as a terrible tragedy resulting in numerous injuries and loss of life, Toyota has been working hard to respond responsibly. By issuing a recall, halting sales, engaging in large-scale public communications, and by acknowledging and apologizing for its errors, Toyota is on its way toward recovery and restoring confidence in its products.

As we have learned in healthcare, introspection, accountability and transparency of information is the best path toward healing. Sometimes, making a mistake, learning from it and implementing changes to make the system better is just what the doctor ordered.

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## PROTECT YOURSELF FROM DIAGNOSIS-RELATED LAWSUITS

In diagnosis cases, you don't have to be right, but you do have to be reasonable: The legal standard of care for diagnosis is that of a reasonable physician in your specialty presented with the symptoms, history, and physical examination of your patient. If you order tests, interpret them, and follow-up in a way that is reasonable, then your actions can be defended in a claim of misdiagnosis or failure to diagnose—even if your diagnosis is wrong.

Here is an actual malpractice case in which the claim was failure to diagnose: Mrs. A, an 82-year-old female, saw

Dr. B, her primary care physician, on day 1 complaining of abdominal pain. The physical exam was unrevealing; vital signs were stable, and the complete blood count test results were normal. No definitive diagnosis was made. The patient was instructed to return if the pain got worse or if other symptoms developed.

On day 11, Mrs. A returned with more complaints of abdominal pain. An exam revealed the patient in no apparent distress. She had a soft abdomen, normal

peristalsis, and no rebound. Her vital signs were normal, and a complete exam with a battery of tests was unremarkable. Dr. B reached a differential diagnosis, gastroenteritis—ruled out cardiovascular distress, and sent Mrs. A to the emergency room for an x-ray of the abdomen. She had a sudden, severe bout of abdominal pain and was taken to the operating room with a diagnosis of a leaking aortic aneurysm. Mrs. A died during surgery.

**Continued on pg. 6— Diagnosis-related lawsuits..**



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**MAKING A DIFFERENCE WHERE IT COUNTS...**

## DIAGNOSIS-RELATED LAWSUITS...CONTINUED FROM PAGE 5

Mrs. A's daughter sued Dr. B, the surgeon, and the hospital for malpractice and wrongful death. The jury returned a defense verdict. (The cost of litigation was around \$50,000.)

Why did the jury find for the defense? Mainly because the jury believed that Dr. B had been reasonable in his diagnosis. It also was helpful that damages were small because Mrs. A was 82 years old, not working, and living with her daughter. Also, proximate cause was weak because experts testified that the result probably would have been the same even if the aortic aneurysm had been diagnosed 11 days earlier.

Other important components of a malpractice decision:

- **Documentation.** In this case, the record carefully documented the rationale for the diagnosis, and that was enough to win over the jury. The chances of defending a similar lawsuit for misdiagnosis ultimately would depend on how reasonable the diagnosis was. Did you listen to the patient's complaints? Did you perform a solid physical exam? Did you order the appropriate tests? Were you informed of the results, and did you relate significant findings to the patient? Is the evidence in the record?
  - **Index of suspicion.** In this case, the fact that the patient is female should have been a clue to look carefully at symptoms besides chest pain. Mrs. A did not present with classic cardiac symptoms: chest pain, shortness of breath, nausea/vomiting, or back/jaw pain.
  - **Seriousness of complaint.** Take the patient's complaints seriously, even if you think the symptoms may be stress-related. Dr. B took Mrs. A's complaints seriously and did a complete work-up.
  - **Follow-up.** In misdiagnosis cases, patients can slip through the cracks, and conditions can go untreated. Treatment over a prolonged period without improvement or testing to determine a definitive diagnosis leaves a physician at risk. Constant monitoring and documentation of the decision-making process make a doctor's position more defensible.
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"Yes, I know hospital bills are outrageous, but he doesn't leave until he's worked it off."