

Important Announcement Regarding Medicaid Integrity Program Provider Audits

To: All Medicaid Providers
From: The Office of Vermont Health Access

Starting in November 2009, the Centers for Medicare and Medicaid Services (CMS) will commence the Medicaid Integrity Program (MIP) provider audits in Vermont. The CMS Medicaid Integrity Group (MIG) is charged by the U.S. Department of Health & Human Services with carrying out the MIP. Medicaid Integrity Contractors (MICs) will conduct the audits. IPRO is under contract with CMS to conduct audits in this region. Review of Medicaid claims data to identify aberrant claims and potential billing vulnerabilities will be conducted by Thomson Reuters. Strategic Health Solutions will provide education for providers.

All Medicaid providers are subject to these audits. The audits will be done on a monthly basis, continuing for an undetermined period.

The objectives of the MIP provider audit program are to audit provider claims and identify overpayments by ensuring that claims are paid:

- for items and services provided and properly documented;
- for items and services billed using the appropriate procedure codes;
- for covered items and services; and
- in accordance with Federal and State laws, regulations and policies.

Frequently Asked Questions (FAQ)

Can you describe the process for an audit?

At the beginning of an audit, the Audit MIC sends the provider a notification letter. Most of the audits are desk audits, where the Audit MIC requests provider documentation and reviews the records at the Audit MIC's office. On some occasions, Audit MICs conduct field audits, in which the auditors actually conduct the audits at the provider's location. All audits are being conducted according to Generally Accepted Government Auditing Standards (Yellow Book). If the Audit MIC concludes, based on the evidence, that there is a potential overpayment, the Audit MIC prepares a draft report which is shared with the State and the provider for comment. Based on these comments, the audit report may be revised. The MIG makes the final decision on any revisions or changes. When the audit report with any associated overpayment is finalized, the MIG sends the final audit report to the State. The State pursues collection of the overpayment from the provider in accordance with the State's laws, regulations, and procedures.

Do the Audit MICs utilize sampling and extrapolation?

Yes. Federal law allows for extrapolation. However, Audit MIC sampling and extrapolation decisions take into account the circumstances of the particular audit and the laws and regulations of the State to which the provider submitted its Medicaid claims.

Is a provider required to make room available for MIC staff during an onsite audit?

Yes. Reasonable requests for space should be honored.

Can MICs request access to non-Medicaid records or patient account information?

Generally speaking, any provider records which are relevant to validating the Medicaid claims under review are legitimate records and may be requested.

Does CMS or the Audit MIC reimburse the provider for the cost of copying medical records?

No.

Do the Audit MICs accept imaged or facsimile medical records?

Yes.

How far back in time will the Audit MICs audit claims?

Generally, the Audit MICs follow the look-back period of the State to which the provider submitted its Medicaid claims. Nevertheless, with MIG approval, the Audit MIC may increase the look-back period.

Additional information regarding the provider audit program: <http://ovha.vermont.gov/for-providers>

- More FAQ about the MIP Provider Audits
- Medicaid Integrity Program A to Z
- MIC Implementation Timeline