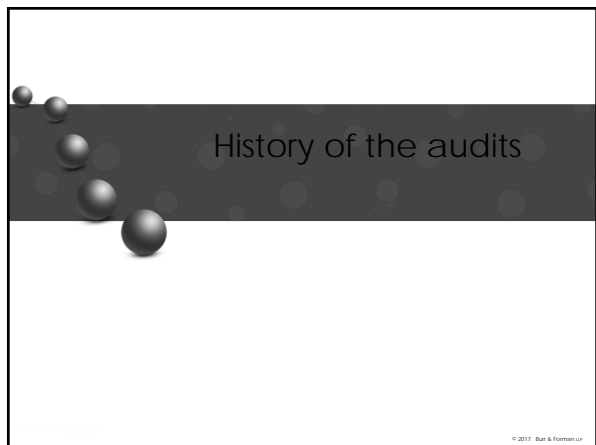


**Alabama Medicaid Audits:
The Good, the Bad and the Ugly**

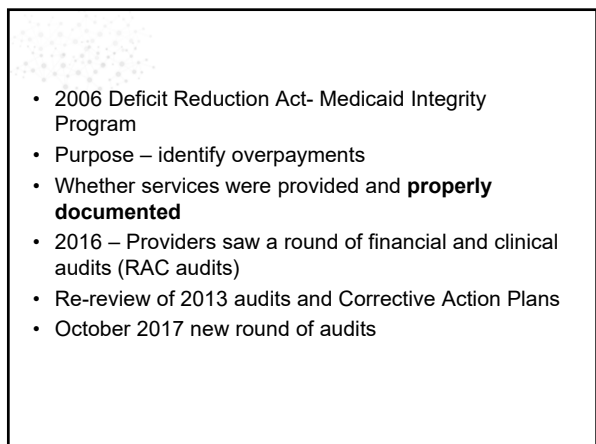
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BURR FORMAN LLP
results matter



History of the audits

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- 2006 Deficit Reduction Act- Medicaid Integrity Program
- Purpose – identify overpayments
- Whether services were provided and **properly documented**
- 2016 – Providers saw a round of financial and clinical audits (RAC audits)
- Re-review of 2013 audits and Corrective Action Plans
- October 2017 new round of audits

- After issuing the October 2017 draft audit letters, met with Medicaid to discuss issues/inconsistencies
 - › Many of the draft audit letters identified missing information that was unrelated to payment
 - › Did not identify which residents were at issue
 - › Identified issues were not related to payment or were an incorrect interpretation of the law
 - › Administrative appeal rights not clearly outlined
- Medicaid agreed to review and reissue draft audit results and allow providers additional time to respond

- Every provider will undergo an audit
- First round is underway
- Unclear how providers chosen or what the review schedule will be
- Initial request for information
- Draft audit report
- Informal conference
- Final audit

- Alabama Medicaid Program Integrity Division**
- Review Process – Provider Review/RAC Unit
- Provider Selection/Referral
 - › Referrals from Medicaid, other agencies and individuals
 - › Complaints
 - › Provider Professional Exception Reports
 - › Follow-up Review from previous audit
 - Request Records/Documentation from Providers
 - Review Records/Documentation submitted by providers

- Draft Audit letter to provider
 - › Additional documentation can be submitted by provider
 - › Informal conference (requested by provider)
- Final Audit Letter to provider
 - › Recoupment amount requested
 - › Fair Hearing Instructions
 - › Corrective action plan ("CAP") to be completed by provider
 - › Provider Education Referral

- Be sure to provide everything requested
- May have to provide documents outside the review period
 - › MDS
 - › Physician progress notes
- If still missing information when you receive draft audit, pay particular attention to what they say is missing.

- In April, we met with Medicaid again to discuss the "fatal piece of paper"
- Medicaid would not identify that "fatal piece of paper"
- Continue to have discussions with Medicaid re: reasons for denials
- Medicaid suggested that we get through the Final Audit Letter phase before bringing our concerns to them

Alabama Medicaid Agency has proposed a new regulation that we feel is directly related to the audits.

Alabama Administrative Code 560-X-1-.21

Proposed regulation change

(5) When records are requested, providers must send all associated documentation that supports the services billed within the timeframe designated in the verbal or written request. Sometimes that information may come from a visit or test performed earlier than the timeframe of the review. Elements of a complete medical record may include but are not limited to:

- (a) Physician orders and/or certifications of medical necessity
- (b) Patient questionnaires associated with physician services
- (c) Progress notes of another provider that are referenced in your own note
- (d) Treatment logs
- (e) Related professional consultation reports
- (f) Procedure, lab, x-ray and diagnostic reports
- (g) Billing provider notes to support the billed date of service
- (h) Delivery logs/tickets
- (i) Itemized statements/invoices
- (j) Prescriptions

Proposed regulation change

(7) A mistaken entry in the record shall be corrected by a method that does not obliterate, white-out, or destroy the entry. Corrections to a record shall have the name or initials of the individual making the correction and the date of the correction.

Proposed regulation change

- 8) Documentation submitted for review may include amended records. Amended records are legitimate occurrences in the documentation of clinical services and include a late entry, an addendum and/or a correction to the medical record. Amended records must:
- clearly and permanently identify any amendment, correction or delayed entry as such,
 - clearly indicate the date and author of any amendment, correction or delayed entry,
 - clearly identify all original content, without deletion, and
 - be amended prior to claims submission and/or medical record request.

Proposed regulation change

- (a) Late entry:** A late entry supplies additional information that was omitted from the original entry. The late entry must:
- include the date the document is amended.
 - be amended upon discovery of the omission but no more than 45 calendar days beyond the date of service, and
 - be entered only if the person documenting the late entry has total recall of the omitted information and signs the late entry.

Proposed regulation change

- (b) Addendum:** An addendum is used to provide information that was not available at the time of the original entry. The addendum must:
- be timely (no more than 45 days beyond the date of service)
 - include the current date (the date the document is amended).
 - include the reason for the addition or clarification of information being added to the medical record, and
 - be signed by the person making the addendum.

Proposed regulation change

(c) Correction: The original content of the medical record should never be written over or otherwise obliterate the passage when an entry to a medical record is made in error. A correction to the medical record must include:

- A single line through the erroneous information, keeping the original entry legible;
- Signature or initial,
- Date the deletion, and
- Statement for the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Proposed regulation change

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Proposed regulation change

Examples of falsifying records include:

- Creation of new records when or after records are requested for review,
- Back-dating entries,
- Post-dating entries,
- Pre-dating entries,
- Writing over,
- Adding to existing documentation (excluding appropriate late entry, addendum and/or correction entries), and/or
- Adding late signatures to the medical record beyond the short delay that occurs during the transcription process (45 calendar days beyond the date of service).

JUST KIDDING
THERE IS NO GOOD


QUESTIONS?


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results matter




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Medicaid Audits: Lessons Learned and How to Reduce Recoupments

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Medicaid Recoupment Codes and Strategies for Dealing with Them

Recoupment Codes

Recoupment Code F2: Provider Signature

- > **Explanation:** Documentation provided for review did not have a physician's signature and/or date
- > Cited the following documents:
 - Physician's orders
 - Progress notes (physicians and nurse practitioners)
 - Psychopharmacological Medication Monitoring Drug Therapy Form

Referenced Policy
Alabama Administrative Code
Rule No. 560-X-1-.18 Provider and Recipient Signature Requirements

- Orders, progress notes, and examinations: Services that are provided or ordered must be signed and dated by the ordering practitioner.
- Treatment Plan Reviews: The reviewing psychologist must sign or initial and date the treatment plan being reviewed.

Recoupment Codes

Recoupment Code F3: Insufficient Documentation to Support Billing

- › **Explanation:** In one instance, there were no progress notes submitted for review.

Referenced Policy
Alabama Administrative Code
Rule No. 560-X-10-.13 Resident Medical Evaluation
 (3) For nursing facilities, the resident must be seen by a physician at least once every 30 days for the first 90 days from admission, and at least once every 60 days thereafter.

Recoupment Codes

Recoupment Code F23: Illegible Signature

- › **Explanation:** The provider's signature is not legible on the documents submitted for review, although signature logs were submitted. In some instances, the provider's illegible signature is different for all 2015 dates of service. Also, in some instances, dates were added after copies were made.

Referenced Policy
Alabama Administrative Code
Rule No. 560-X-1-.18 Provider and Recipient Signature Requirements
 (1) Definitions (b) Handwritten Signatures: A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. Provider signatures must be legible and clearly identify the provider performing the billed service. Illegible provider signatures must be supported by a valid signature log or attestation statement to determine the identity of the author. A handwritten signature must be an original signature on the original record or document; it must not be a photocopy or otherwise adhered to the original document.

Recoupment Codes

Recoupment Code F36: No Order for Continued Stay

- › **Explanation:** The physician's orders submitted for review did not include the following:
 - An "I certify" statement. The orders stated, "Admit to FACILITY" for initial admission date and "Continue ICF/SNF (circle) Nursing Home Care for resident" for continuation of stay.
 - NOTE: In some instances, the physician order form with the original signature was submitted for review.

Referenced Policy
Alabama Administrative Code
Rule No. 560-X-10-.10 Admission Criteria
 • (a) The physician must state "I certify" need for admission and continuing stay.
Rule No. 560-X-6-.10 Physician's Role in Certification and Recertification
 • (1) For information about hospital certification/recertification see Rule No. 560-X-7-.16.
 • (2) In a skilled or intermediate nursing care facility, in the hospital and for the Home Health Care Program, Medicaid patients must be recertified by a physician at least every sixty (60) days. The certification form will be made a permanent part of the patient's record.

Recoupment Codes

Recoupment Code F37: PASRR Documentation Incomplete/Noncompliant with Guidelines

- › Explanation: The PASRR documentation submitted for review was incomplete and/or noncompliant with guidelines.
- › The Level 1 Screening, DATE, submitted for review, list recipient name as John Example; PASRR for Franklin B. Example not submitted.

Recoupment Codes

Recoupment Code F37: PASRR Documentation Incomplete/Noncompliant with Guidelines

Referenced Policy
Alabama Administrative Code

Rule No. 560-X-10-.11 Establishment of Medical Need

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews

1. New Admissions
 - (i) Admission and Evaluation Data (Form 161). The provider must maintain supporting documentation for the admission criteria required by Rule 560-X-10-.10 listed on the Form 161.
 - (ii) A fully completed Minimum Data Set.
 - (iii) Records of PASRR evaluations and determinations
2. Readmissions
 - (i) Admission and Evaluation Data (Form 161).
 - (ii) Updated PASRR screening information for a significant

Recoupment Codes

Recoupment Code F40: MDS Documentation Incomplete/Noncompliant with Guidelines

- › Explanation: The Minimum Data Set (MDS) dated DATE submitted for review was not signed by an RN verifying assessment completion as specified in Section Z0500 on the form. Additionally, there is no valid reviewer signature on the document. The signature should be that of an RN, not a LPN.

Recoupment Codes

Recoupment Code F40: MDS Documentation Incomplete/Noncompliant with Guidelines

Referenced Policy

Alabama Administrative Code

Rule No. 560-X-10-.11 Establishment of Medical Need

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews

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(ii) A fully completed Minimum Data Set.

(iii) Records of PASRR evaluations and determinations

2. Readmissions

(i) Admission and Evaluation Data (Form 161).

(ii) Updated PASRR screening information for a significant

The Medicaid Agency has delegated authority for the initial level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

(a) The process to establish medical need includes medical and financial eligibility determination.

1. The determination of level of care will be made by an RN of the nursing facility staff.

2. Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.

Recoupment Codes

Recoupment Code F43: Form 161 Signed by Reviewer After Date of Admission

- › Explanation: Form 161 was signed by the physician on DATE, which was after the Medicaid Admission Dates, DATE and DATE. Therefore, the admissions were not certified by the facility's physician prior to admission as required by the Alabama Medicaid policy.

Recoupment Code F43: Form 161 Signed by Reviewer After Date of Admission

Referenced Policy

Alabama Administrative Code

Rule No. 560-X-10-.11 Establishment of Medical Need

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

1. New Admissions

(i) Admission and Evaluation Data (Form 161). The provider must maintain supporting documentation for the admission criteria required by Rule 560-X-10-.10 listed on the Form 161.

(ii) A fully completed Minimum Data Set.

(iii) Records of PASRR evaluations and determinations

2. Readmissions

(i) Admission and Evaluation Data (Form 161).

(ii) Updated PASRR screening information for a significant

Alabama Medicaid Provider Manual

26.3 Establishment of Medical Need

- A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

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