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by Cornelia M. Dorfschmid, PhD and Lisa Shuman, MPA

Medicaid vs. Medicare claims audit appeals: A road less clear

- Medicaid claims audits are different from Medicare audits and conducted by various government entities and contractors.
- Government entities and contractors must follow Generally Accepted Government Auditing Standards (GAGAS).
- Key differences between Medicaid audits and Medicare audits are record request limits and current look-back periods in use.
- Conditions necessary for overpayment extrapolation may vary.
- When faced with a Medicaid or Medicare audit with extrapolation, engage an experienced healthcare attorney and statistician.

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In recent years the enforcement climate has become harsher than ever before as more and more providers experience significant recovery demands resulting from claims overpayment extrapolations made by Medicare and Medicaid contractor audits. In Medicare in particular, the Medicare Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs) very actively audit claims to identify and recover inappropriate payments. In Medicaid, claims audits for recovery purposes are conducted by Medicaid RACs (M-RACs) and Medicaid Integrity Contractors (MICs), among others. Although the appeals processes differ from each other and requirements on auditors vary, one should keep in mind that there are general standards that set overarching requirement for government auditors. The auditors have to conduct their work according certain professional standards that allow for inter-rater reliability, independence, and objectivity and must follow Generally Accepted Government Auditing Standards (GAGAS). If they don't, the results may be subject to challenge.

GAGAS

Dorfschmid

Shuman

Government auditors are to follow professional standards and guidance contained in the GAGAS, which are commonly referred to as the "Yellow Book" because of the distinctive bright yellow cover of the hard copy version. GAGAS provide a framework for conducting high-quality audits with competence, integrity, objectivity, and independence. The Yellow Book is issued by the Comptroller General of the United States in the Government Accountability Office (GAO). The Yellow Book was revised for 2011 to replace the 2007 version and is now also available as a PDF version on the GAO website.[1] GAGAS contains standards for audits of government organizations, programs, activities, and functions, and of government assistance received by contractors, nonprofit organizations, and other nongovernment organizations. GAGAS are to be followed by auditors and audit organizations when required by law, regulation, agreement, contract, or policy. These standards pertain to auditors' professional qualifications, the quality of audit effort, and the characteristics of professional and meaningful audit reports. When appealing some of the auditor's

findings or processes that led to the findings or demands, it is useful to keep in mind that the auditors are subject to these standards and practices that comply with such standards.

Medicare appeals of claims

Adverse findings in a Medicare contractor's claims audit are appealable using the Medicare appeals process that follows a standard set of steps. Further, the rules for when and how overpayment extrapolations can be performed and if so, how they must be conducted, are set forth in the Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual* (PIM). Medicare RACs use statistical sampling to project the amount of overpayments made on claims. According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare RACs may only use extrapolation to determine overpayment amounts to be recovered by recoupment under one of two conditions: (1) there is a sustained or high level of payment error; or (2) documented educational intervention has failed to correct the payment error. Furthermore, by law, the determination that a sustained or high level of payment error exists is not subject to administrative or judicial review.[2] At least one of the two conditions must apply before a contractor can extrapolate, hence there should at least be evidence to support the condition, even if how the condition was confirmed is not appealable.

The Medicare appeals process and rules are by now reasonably well understood by the industry and have been discussed in many industry forums and by trade associations. With the implementation of the *Medicare Integrity Program Manual*, CMS benefit integrity and medical review contractors conducting audits on behalf of CMS also needed to become more formalized and sophisticated in their methods to consistently perform than any prior recovery auditors.

Medicare auditors: RACs and ZPICs

Audit findings of RACs and ZPICs follow the same claims appeals process. There are five levels in the claims appeals process under Original Medicare (Part A and B):

1. Redetermination by a CMS affiliated contractor (i.e., Carrier or Fiscal Intermediary) or Medicare Administrative Contractor (MAC).
2. Reconsideration by a Qualified Independent Contractor (QIC).
3. Hearings before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals in the Department of Health and Human Services.
4. Review by the Appeals Council within the Departmental Appeals Board in the Department of Health and Human Services.
5. Judicial review in federal district court.

Medicaid appeals of claims

The Medicaid appeals process and roles of contractors and auditors in this process, however, is a road much less clear and consistently formalized. In comparison to the Medicare RAC program and the Medicaid Integrity Contractor, which are run and operated by CMS, the Medicaid RAC program is administered by the states.[3] In essence, it is dependent on state law. Further, in contrast to the Medicare RAC extrapolation process, the *Medicaid Program Integrity Manual* states that sampling and extrapolation was used during test audits, but extrapolation from samples is not currently being used in audits carried out as part of the National Audit Program. The CMS Medicaid Integrity Group (MIG) plans to systematically pursue greater use of extrapolation in the future as the data is refined.[4] Hence there are as many nuances and variations in the appeals process as there are states. It is prudent to be aware of some of the key differences in rules Medicare and Medicaid government auditors and appellants have to play by.

Medicaid contractors: MICs and Medicaid RACs

The Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act. The Medicaid Integrity Contractors (MICs) are national CMS contractors. Under MIP, CMS hires Audit Medicaid Integrity Contractors (Audit MICs) to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. CMS also assists states in their efforts to fight against Medicaid provider fraud and abuse. There are three types of MICS (Audit, Review, and Education) in five jurisdictions, each covering two CMS regions: New York (CMS Regions I & II), Atlanta (CMS Regions III & IV), Chicago (CMS Regions V & VII), Dallas (Regions VI & VIII), and San Francisco (CMS Regions IX & X).

The MIC audit process by these national CMS contractors is different than other CMS audit processes, such as those used by MACs and RACs. For example, in contrast to CMS Medicare contractors such as RACs, Audit MICs are not bound by the limits on the number of claims records they can request in each audit, although they may only review claims five years prior to the start date of the audit.[5] Furthermore, the scope of the MIC audit can be large and each state will have a different process. The appeals process is managed at the state level and will vary from one state to the next, based on state guidelines. Note that state Medicaid agencies must defend MIP audit findings in administrative appeal or judicial proceedings as if they are their own, although they can challenge MIC findings by filing an appeal through the Department of Health and Human Services (HHS) Departmental Appeals Board Appellate Division.

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Medicaid Recovery Audit Contractors (Medicaid RAC Program)

Medicaid RACs are state contractors rather than national contractors. States are required to enter into contracts with one or more eligible Medicaid RACs. The Medicaid RACs review claims submitted by providers of items and services or other individuals delivering items and services to identify underpayments and overpayments and recoup overpayments for the states. States must coordinate the recovery audit efforts of their Medicaid RACs with other auditing entities. States must also set limits to the number and frequency of medical records to be reviewed by the Medicaid RACs. Medicaid RACs must notify providers of overpayment findings within 60 calendar days and not review claims that are older than three years from the date of the claim, unless they receive approval from the state. Furthermore, the states must provide appeal rights under state law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination. CMS does not require states to adopt a new administrative review infrastructure to conduct Medicaid RAC appeals, as long as states can carry out Medicaid RAC appeals within their existing Medicaid provider appeal structure.

Comparing Medicare and Medicaid audit and appeal processes for claims

Table 1 shows a brief comparison between the Medicare RACs, the M-RACs, and the MICs. Some of the requirements or limitations imposed on auditors should be kept in mind when formulating a defense or appeals strategy. The Medicaid RACs and MICs have different rules regarding the "look back" period and the limitations for record requests. Note, however, that the American Tax Relief Act of 2012 (ATRA) extended the look back to five years. Further, the Medicare RACs have a different appeals process than the Medicaid RACs and MICs, which follow state regulations.

The scope of this article only allows for a few state examples. Table 2 shows an excerpted

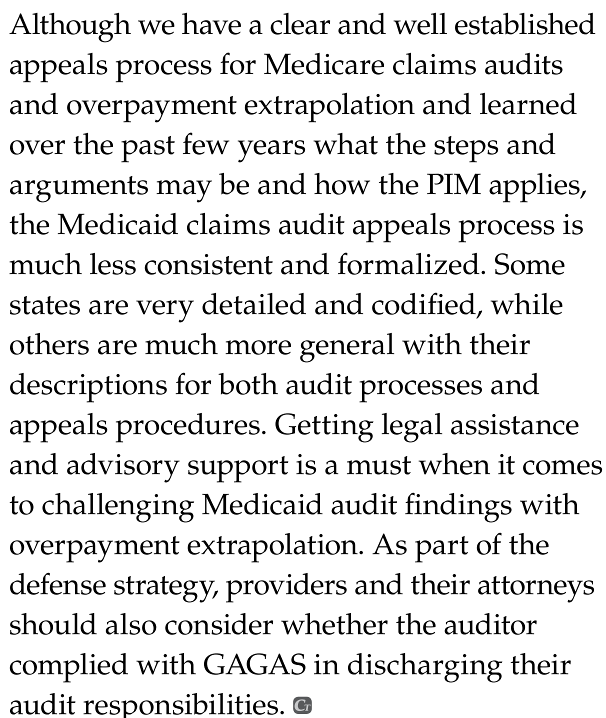
Table 1: Comparison between Medicare RACs, Medicaid RACs, and MICs

	Medicare Recovery Audit Contractors (Medicare RACS)	Medicaid Recovery Audit Contractors (Medicaid RACs)	Audit Medicaid Integrity Contractors (MICs)
Background	Section 302 of the Tax Relief and Healthcare Act of 2006 required the Secretary of the Department of Health and Human Services to institute a permanent nationwide Recovery Audit program by 2010. (CMS Recovery Audit Program Website, Recovery Audit Program and Medicare Slides).[7]	Section 6411(a) of the Affordable Care Act established Section 1902(a)(42) of the Social Security Act, which required States and territories to form Medicaid RAC Programs consistent with state laws by January 1, 2012 (MIP, Ch. 1).	Section 1936 of the Social Security Act establishes the Medicaid Integrity Program, which authorizes the Centers for Medicare & Medicaid Services (CMS) to enter contracts with Medicaid Integrity Contractors (MICs) (42 CFR § 455.200).
Purpose	A program administered by CMS to review claims submitted by providers to identify underpayments and overpayments and recoup overpayments (42 CFR § 455.504).	A program administered by the state to review claims submitted by providers to identify overpayments underpayments and overpayments and recoup overpayments for the states (42 CFR § 455.506).	Under the contract with CMS, the MIC may (1) review the actions of individuals and entities to detect fraud, waste, or abuse; (2) audit claims and identify overpayments; and (3) educate providers, entities, beneficiaries, and individuals about payment integrity and quality of care (42 CFR § 455.232).
Fraud Referrals	A Recovery Auditor may receive provider referrals from CMS or other CMS contracting entities (CMS, Statement of Work for Recovery Audit Program).[8]	Required to make referrals of suspected fraud and/or abuse, to the Medicaid Fraud Control Unit (MFCU) or other relevant law enforcement agency (42 CFR § 455.506).	Required to make a referral to the MIG and the OIG. The OIG must notify and provide information to the appropriate MFCU within 14 days of receiving the referral. The OIG has 60 days to determine whether to accept the referral (42 CFR 455.230) (MIP, Ch. 10).
Look Back Period	3 years past the date of the initial determination made on the claim (CMS, Statement of Work for Recovery Audit Program).[9]	3 years from the date of the claim, unless the state approves otherwise (42 § 455.510).	5 years from the start of the audit (date engagement letter is sent to provider) (MIP, Ch. 10).
Request for Records	Limit the number of Medical record requests (CMS, Statement of Work for Recovery Audit Program).[10]	States must set limits on the number and frequency of medical records to be reviewed by the RACs (42 § 455.506).	N/A
Appeals Process	Five Levels of Appeal: 1) Redetermination 2) Reconsideration 3) Administrative Law Judge hearing 4) Medicare Appeals Council review 5) U.S. District Court	The appeal process is determined by each state according to rights under state law or administrative procedures to Medicaid providers (42 § 455.512).	The appeal process is determined by each state and according to the state's Medicaid program requirements. State Medicaid Agencies are required to defend MIP audit findings in administrative appeal or judicial proceedings (MIP, Ch. 10).

Table 2: Comparison Between the Texas, California and Florida Appeals Process

Texas Appeals Process	California Appeals Process	Florida Appeals Process
RAC APPEAL (Texas Administrative Code, Title 1, Part 15, CH. 354, Rule §354.1451) **Scope of RAC Audit:** (1) Review Medicaid claims. (2) Analyze Medicaid paid claims data to ensure services were provided based on federal and state policies. (3) Make referrals of fraud/abuse to Texas Health and Human Services Commission (HHSC) Office of Inspector General. **Response/Informal Appeal:** The provider can submit a response to a draft audit report or informally appeal the findings in the draft audit report no later than the 30th day after receipt of the draft audit report. The informal appeal involves a desk review by the auditing division or entity. **Appeal Process:** For HHSC paid Medicaid claims, the provider appeals through the Medicaid Program Appeals Procedures under §354.2217. For HHS Agency Paid Medicaid Claims, the provider follows appeal process for that HHS agency. **PROVIDER APPEALS PROCEDURES (Texas Administrative Code, CH. 354, Rule §354.2217)** **Submission:** An administrative or medical appeal must be: (1) submitted to HHSC Medicaid/CHIP Administrative Claim and Medical Appeals after the appeals process with the claims administrator or claims processing entity has been exhausted; (2) received within 120 days from the date of disposition; (3) received within 18 months from the date of service. **Processing/Decision:** An administrative claim or medical appeal will be reviewed and a determination made by HHSC within 90 days of the date a complete request for appeal is received at HHSC. **Utilization Review Appeals:** Must be received by HHSC within 120 days from the date of the decision letter from HHSC Medicaid Fraud and Abuse Utilization Review.	**PROVIDER AUDIT APPEALS (California Administrative Code, Title 22, Division 3, Ch. 3, Article 1.5)** **Request for Hearing for any disputed audit or examination:** Institutional provider: Send a written request within 60 calendar days of the receipt of the written notice of the audit or examination findings. Non-institutional provider: Send a written request within 30 calendar days of the receipt of the audit or examination finding (§51022). **Informal Level of Review:** If a hearing officer decides that an informal level of review is appropriate, it will be ordered and scheduled as soon as reasonably possible (§51024). **Request for Formal Hearing:** Institutional provider: Has 30 calendar days after the receipt of the written Report of Findings to file a request for formal hearing with the director. A formal hearing is routinely scheduled in each case for a non-institutional provider (§51024). **Reconsideration:** The Department may order a reconsideration of all or part of the case on its own motion or on petition of any party. A reconsideration must be ordered within 30 calendar days after delivery or mailing of a decision to the provider (§51024). **Judicial Review** (§51026). **CLAIMS APPEAL (Medi-Cal Provider Manual-Part 1-Medi-Cal Program and Eligibility)** **Submission:** Providers must submit a complaint in writing to the Fiscal Intermediary (FI) that describes the disputed action or inaction within 90 days of the action/inaction. **Processing/Decision:** The FI acknowledges each written complaint within 15 days and makes a decision within 45 days of receipt. If the FI is unable to make a decision within this time period, the appeal is referred to the professional review unit for an additional 30 days. Note, providers who are not satisfied with the decision may file a suit in a local court, not later than one year after the appeal decision. The Department of Health Care Services (DHCS) would be the defendant.	**PROVIDER APPEALS PROCESS (2012 Florida Statutes, Title XXX, CH. 409, Part III)** **Request for Hearing:** A provider can request an administrative hearing according to chapter 120. The hearing must be conducted within 90 days following assignment of an administrative law judge, "absent exceptionally good cause" demonstrated as determined by the administrative law judge or hearing officer (409.913). **(2012 Florida Statutes, Title X, CH. 120)** **Summary Hearing:** Within 5 business days after the division's receipt of a petition or request for hearing, the division will issue and serve on all original parties an initial order that assigns the case to a specific administrative law judge and provide general information about practice and procedure before the division Within 15 days after service of the initial order, any party may file a motion for summary hearing. If all original parties agree, in writing, to the summary proceeding, the proceeding will be conducted within 30 days of the agreement. The administrative law judge must make a decision within 30 days after the end of the final hearing or the filing of the transcript, whichever is later. The decision is subject to judicial review (120.574). **Judicial Review:** A party who is adversely affected by final agency action is permitted to judicial review. A notice of appeal or petition for review must be filed in accordance with the Florida Rules and Appellate Procedure within 30 days after the "rendition of the order being appealed" (120.68).

comparison between the appeals process in Texas, California, and Florida according to the Administrative Codes, Statutes, and Medicaid Provider Manuals. Based on the MFCU statistical data, these three states are among those with high levels of fraud, and have large recovery amounts.[6] The state comparison is to exemplify that states may have quite different processes for appealing audits vs. claims. Especially when a government auditor has findings involving overpayment extrapolation, it would be prudent for the provider to seek legal assistance to ensure the appropriate appeals route is chosen. Medical and statistical consultants should be conferred with to ensure the claims are interpreted correctly and the statistical projection are correct and within applicable federal or state guidelines and professional standards. When considering the various appeals processes set forth by states, one may note that there may be a different process for appealing Medicaid RAC audits vs. state OIG audits, as seen in Texas for example. Further, certain states clearly and in detail describe the Medicaid RAC appeal process, such as Texas, while other states have more generalized appeal procedures. Lastly, each state has different timelines for complaint submissions or hearing requests.



Conclusion

Although we have a clear and well established appeals process for Medicare claims audits and overpayment extrapolation and learned over the past few years what the steps and arguments may be and how the PIM applies, the Medicaid claims audit appeals process is much less consistent and formalized. Some states are very detailed and codified, while others are much more general with their descriptions for both audit processes and appeals procedures. Getting legal assistance and advisory support is a must when it comes to challenging Medicaid audit findings with overpayment extrapolation. As part of the defense strategy, providers and their attorneys should also consider whether the auditor complied with GAGAS in discharging their audit responsibilities.

1. Government Auditing Standards, December 2011 Revision. http://www.gao.gov/yellowbook
2. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. no 108-173 (2003). See also CMS Medicare Program Integrity Manual Chapter 8.4.1.2
3. Medicaid RACs A Service of HMS. "FAQ" 2013.
4. Centers for Medicare & Medicaid Services. Medicaid Program Integrity Manual, 100-15, CH. 9, Data Analysis. 23 Sept. 2011.
5. Centers for Medicare & Medicaid Services. Medicaid Program Integrity Manual, 100-15, Ch. 10, Medicaid Integrity Audits. 23 Sept. 2011.
6. See MFCU Statistical Data for Fiscal Year 2012. http://1.usa.gov/15U7T9K
7. See http://go.cms.gov/19FIKEZ2
8. *Id.*
9. *Id.*
10. *Id.*

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