New Jersey Implements Its Medicaid Recovery Audit Contractor ("RAC") Program Ahead of Schedule

Client Advisories

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Corporate compliance and quality control programs can avert problems

A key but relatively unknown provision of the health care reform law enacted in March 2010 authorized the extension of the Medicare RAC program to state Medicaid programs (P.L. 111-148, the Patient Protection and Affordable Care Act or "PPACA"). Section 6411 of PPACA expanded the RAC (Recovery Audit Contractor) program to Medicaid. Although the U.S. Department of Health & Senior Services has yet to issue regulations governing this extension of the RAC program, New Jersey has entered into a Medicaid RAC contract, and implemented the extension effective August 1, 2011.

Based on what the government considered the success of the Medicare RAC program over the past five years, Congress expanded the program to cover state Medicaid agency payments. Medicare RACs are private subcontractors authorized to perform audits of Medicare payments to health care providers and to be paid a percentage of their recoveries. Their goal under Medicaid, as it has been under Medicare, will be to audit payments and identify and recover overpayments.

In New Jersey, effective August 1, 2011, a company called Health Management Systems (HMS) is the RAC, and will conduct audits of Medicaid payments to long-term care facilities, home health agencies, hospices, adult day health facilities, laboratories, and individual providers such as physicians and chiropractors - literally any provider that bills for services under Medicaid or a Medicaid waiver program. HMS will not work alone; the law requires the contractor to coordinate its recovery audit efforts with other contractors or entities performing audits of providers receiving payments under the Medicaid State plan or waivers in the State, including efforts with federal and state law enforcement. The Medicaid Fraud Division (MFD) of the State Comptroller's Office (formerly the Medicaid Inspector General) will oversee and coordinate the efforts of HMS, and HMS will report its audit findings to both MFD and the Division of Medical and Health Services (DMAHS). MFD may also direct

HMS to audit specific provider types, or specific providers that MFD believes pose a higher risk of Medicaid overpayments.

Two Types of Audits

HMS will conduct two types of audits: Automated Reviews and Complex Reviews.

Automated Review: An Automated Review is one in which HMS determines that improper payments can be determined "clearly and unambiguously," without extensive document review. In these cases, a provider's first contact from HMS will be an Improper Payment Notification letter, indicating the perceived payment error, informing the provider of the related regulation or policy, and the amount of the improper payment. The provider then will have the opportunity to respond to each finding and provide additional information. After a review and re-evaluation, HMS will issue a final determination. If HMS still finds that an improper payment was made, it will specify the amount, the recovery process, and the provider's appeal rights.

Complex Review: A Complex Review is one in which HMS has identified a potentially improper payment that cannot automatically be validated. In such cases, claims are flagged for further review, and HMS will contact the provider to request documentation (usually medical records). HMS indicates it will use a statistically significant sample - MFD in the past has requested 5, 25 or 50 records, but HMS will likely request a percentage of cases. Each participant's records and claims can be reviewed for up to a three-year look-back period. HMS may elect to extrapolate the results from the sample to the entire patient population. HMS staff, consisting of certified coders and registered nurses, then will review the documentation to determine if an improper payment exists. Notably, a nurse or coder cannot deny a claim, but must refer their recommendation for denial to a physician for a final decision. After this process is completed, a final determination notice is sent to the provider. This letter will specify the amount of the improper payment, the recovery process, and the provider's appeal rights.

Final determinations can be appealed to the Office of Administrative Law, and ultimately to the Appellate Division of New Jersey Superior Court. A provider will have 20 days from the final determination letter to file its Notice of Appeal. The letter should contain the specific address where the Notice of Appeal is to be filed.

In the event that HMS discovers possible criminal activity as part of its review, it will refer its findings to MFD and the Medicaid Fraud Control Unit of the Attorney General's Office.

Contingent Fee Payment

HMS is not a government agency, but a private contractor, which must be paid for its services. HMS will not be paid with tax dollars, but by a percentage of the "improper payments" it recovers. On Automated Reviews, HMS will be paid 9% of any overpayments it recovers, and 9% of any underpayments it discovers. On Complex Reviews, HMS will be paid 12.5% of any overpayments it recovers. Providers should be aware that, regardless of whether improper payments are found or not, they will not be reimbursed for photocopying records, which could be quite costly.

Recommendations

It should go without saying that facilities and individual providers who bill Medicaid must avoid the classic improprieties, such as billing for more patients in a day than can reasonably be seen, billing for services not rendered, double billing, up-coding and mis-coding, and billing for services that are not medically necessary. But MFD has made it clear in recent cases that it considers billing for poor quality of care to be a form of fraud, waste and abuse as well. Even if it is not mandatory, all providers are urged to maintain a corporate compliance program, designed to prevent and detect any fraudulent practices, and to ensure that employee and vendor credentialing is complete and sufficient documentation of care is in place to satisfy a Medicaid RAC audit. External compliance audits are recommended to ensure the thoroughness of the provider's compliance programs. Providers should be aware that MFD has stated that employees' status must be checked monthly to ensure they are not listed on the federal and state exclusion data bases.

If you have questions or concerns related to the new RAC program or other health care law or Medicaid matter, please contact Robert J. Fogg or William P. Isele of Archer's Health Care Practice Group at (609) 580-3700 in Archer's Princeton, N.J., office.

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