Administrative Code

Title 23: Medicaid
Part 304
Audit

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Rule 1.1: Audit Rule

A. General: It is the mission of the Division of Medicaid to ensure compliance, efficiency, and accountability within the Mississippi Medicaid program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance. The Division of Medicaid shall conduct auditing and monitoring reviews of Medicaid providers accordingly.

B. Audit and Monitoring Reviews

1. The Division of Medicaid utilized bureau staff, contracted audit entities or combination of both, selects Medicaid providers for review.

2. An audit or monitoring review has the following objectives:

   a) To determine if services billed and paid under the State's Medicaid program were:

      1) Provided to an eligible beneficiary,

      2) Medically necessary,

      3) Provided at the appropriate level of care,

      4) Appropriately documented,

      5) In accordance with the Mississippi Medicaid Provider Manual, Mississippi State Plan, and official notices through other means such as, but not limited to, the Mississippi Medicaid Provider Bulletin, Remittance Advice header messages, and official communications from the Agency, and

      6) For service for which the reimbursement rate is based on a cost report, that the cost report contains only allowable costs and were completed in accordance with the Mississippi Medicaid Provider Manual, the Cost Report Instructions as posted on the Mississippi Medicaid website and Mississippi State Plan.

   b) To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations,

c) To provide a mechanism for data gathering this can be used to modify the State's Medicaid program and State Medicaid Rules and procedures,

d) To determine if the services provided meet the community standard of care, and

e) To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the review period.

C. Audit Methods and Locations: The Division of Medicaid selects the appropriate method of conducting the review including, but not limited to, the following:

1. On-site reviews, conducted on the provider's premises,

2. Desk audits, conducted at the Division of Medicaid's or contracted auditor's offices, or

3. A combination of an on-site and a desk audit.

D. Audit/Monitoring Review Overview

1. Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Providers must:

   a) Keep legible, accurate, and complete charts and records to justify the services provided to each client,

   b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains, and

   c) Make charts and records available to Medicaid staff, it contractors, and the U.S. Department of Health and Human Services upon request. Records shall be maintained in accordance with Part 200, Chapter 1, Rule 1.3.

2. A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

3. If a provider fails to participate or comply with the Division of Medicaid's audit process or unduly delays the audit process, the Division of Medicaid considers the provider's actions or lack thereof, as abandonment of the audit.

4. If the Division of Medicaid suspects a provider of fraud, abusive practice, audit abandonment, or present a risk of imminent danger to clients, the Division of Medicaid shall take one or more of the actions listed below.

a) Immediately issue a final report,

b) Terminate the provider's agreement with Medicaid,

c) Issue a subpoena for the provider's records, or

d) Refer the provider to the appropriate prosecuting authority.

E. Audit/Monitoring Review Process: In general, the audit/monitoring review process will consist of the following:

1. Provider Notification,

2. Field Entrance Conference,

3. Procedures for Submitting Documentation Electronically,

4. Examination of Documentation,

5. Field Exit Conference,

6. Draft Report,

7. Exit Conference,

8. Final Report, and

9. Administrative Hearings as required.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: False Claims Act

A. General

1. Section 6032 of the federal Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) set forth administrative requirements which impacts entities receiving annual Medicaid payments of at least $5,000,000. The DRA requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to provide employee education regarding the False Claims Act and take actions that will address fraud, waste and abuse in health care programs that receive federal funds. Any entity that receives $5,000,000 or more annually must establish the following policies as a condition of participation in the Medicaid program:

a) The entity must establish written policies for all employees of the entity including management and of any contractor or agency of the entity that provides detailed

information about the False Claims Act established under Sections 3729 through 3733 of Title 31, United States Code.

b) The entity must include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

c) The entity must include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

2. Annually, the Division of Medicaid will identify and mail notices to providers and contractors that provide Medicaid health care items or services that were paid $5,000,000 or more during the prior federal fiscal year. The $5,000,000 threshold will be measured based upon the aggregate payments received by an entity during the federal fiscal year October 1 through September 30, even if that entity has multiple provider and/or tax id numbers. For example, a health system that includes a hospital, skilled nursing facility and home health program and collectively receives more than $5,000,000 in aggregate reimbursement annually will be subject to this requirement. Once notified, the entity will have thirty (30) calendar days to submit the documentation requested in the letter to confirm compliance.

3. It is the responsibility of each entity meeting the annual threshold to establish and disseminate written policies. In addition, the entity must provide those policies to the Division of Medicaid including any revisions. The Division of Medicaid will perform annual monitoring activities to ensure that entities are in compliance with this section. Providers will be selected on a random basis or as needed.

4. If an employee or contractor or agent of an entity reports suspected fraud, waste, or abuse in the Medicaid program, the entity must report that information to the Bureau of Program Integrity at the Division of Medicaid by the next business day. Entities must investigate all allegations within a reasonable time period and report the results of the investigation to the Division.

B. Reporting Requirements - False Claims information must be reported to the appropriate federal and/or state entity including Medicaid and the Federal Office of Inspector General in the U.S. Department of Health and Human Services.

C. Sanctions - If an entity is found not to be in compliance with any part of the requirements noted above, the provider will be given a thirty (30) day notice by the Division of Medicaid that suspension of the entity's provider number(s) and payment may be held at the sole discretion of the Division of Medicaid. The entity must submit appropriate documentation to the satisfaction of the Division of Medicaid in order for the non-compliance status to be lifted. The Division of Medicaid will work in conjunction with the Attorney General's office and the Office of the Inspector General (OIG) on cases of non-compliance.

D. Definitions- For purposes of this rule Medicaid defines the terms used as follows:

1. Entity - An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit or not-for-profit, which receives or makes payment, under a State Plan approved under title XIX or under any waiver of such plan. In addition, persons are considered entities. A "person" includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business or trust. If an entity furnishes items or services at more than a single location or under more than once contractual or other payment arrangement, the provisions of this section will apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

2. Employee - An "employee" includes any officer or employee of the entity.

3. Contractor or Agent - A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

4. Knowingly - "Knowing" and "Knowingly" is defined to mean that a person:

   a) Has actual knowledge of falsity of information in the claim,

   b) Acts in deliberate ignorance of the truth or falsity of the information in a claim, or

   c) Acts in reckless disregard of the truth or falsity of the information in the claim. The federal False Claims Act does not require proof of a specific intent to defraud the United States government. Instead, entities can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to Medicaid. Examples include knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

5. Whistleblower - An individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under Sections 31 USC 3729 through 3733 which is based on the information.

6. Claim - A "claim" includes any request or demand for money that is submitted to the Division or its fiscal agent.

E. Appeals - Refer to Part 300, Chapter 1, Rule 1.1 for the rule regarding Administrative Hearings for Providers.

Source: Miss. Code Ann. § 43-13-121