When Things Go Wrong
What Is Your Recourse?

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Act 1499 of 2013
Medicaid Inspector General

- Detection, prevention and recovery
- What?

Fraud

- Knowingly providing false information or omits material information for payment not entitled to (p.1/29; p.3/5)

Abuse

- Provider practices inconsistent with sound fiscal, business or medical practices and results in unnecessary costs to Medicaid (p.2/34)

What MIG Must Do

- Prevent, detect and investigate fraud and abuse (p. 4/23)
- Review provider records – 3 years back without allegation (p. 5/4)
- Review provider records – 5 years back with allegation (p. 5/7)
- Solicit, review and investigate complaints (p. 5/23)
- Subpoena witnesses (p. 6/30)
- Maintain hotline for reporting (p. 9/21)
- Compel production of documents (p. 6/34)
- Implement policies related to prevention and detection (p. 7/19)

What MIG Must Do – cont.

- Review and audit contracts, claims, bills and other expenditures of Medicaid funds (p.8/2)
- Conduct educational programs for providers (p.8/17)
- Develop protocols for self disclosure (p.8/27)
- Conduct on-site inspections (p.9/6)
- Use quality improvement organization to assess quality (p.10/12)
- Create and make available on website guidelines for compliance program including a model compliance program (p.16/12-14)
- Request annually updated certification from providers of compliance program (p.18/22-23)
- Adopt regulations for implementing compliance program (p.18/34)

What DHS Must Do

- Enter into agreement with a fiscal agent for data mining to detect and control fraud, waste and abuse (p.13/12)
- Implement automated process to improve coordination of benefits between Medicaid and other coverage (p.13/19)
- Examine retrospective review of claims paid (p.13/23)
- Examine savings through prospective pre-claims payment review (p.13/33)
- Monitor and analyze claims and utilization data and implement automated process for claims review for statistical aberrations and proper coding (p.13/25; p.14/1-31)
- Review services for coding errors, incorrect or multiple billing for same service, excess billing or service use (p.14/32; p.15/8-11)
- Issue advisory opinions requested by Medicaid provider (p.17/29-30)

What Providers Must Do

- Medicaid providers receiving annually $750,000 or more from Medicaid must adopt and implement a compliance program (p.16/8-11)
- Compliance program must be adopted by Medicaid provider within 90 days after the regulation is promulgated by MIG (p.19/2-4)

What Providers Must Do – cont.

- Compliance program must be in writing and must include:
  - Compliance expectation
  - Operation of program
  - Guidance to employees
  - Method of communicating compliance issues to compliance personnel
  - Methods of investigating compliance problems
  - Designation of an employee responsible for operating the compliance program
  - Provide compliance program training to employees
  - Provide disciplinary policies to encourage participation by employees

MIG Act

- Effective July 1, 2013
- Due Process Provisions of MFA apply

Act 562 of 2013
AR Medicaid Fairness Act

- Passed in 2005
- Amended in 2007
- Amended in 2013

AR Medicaid Fairness Act: A.C.A. § 20-77-1704

- Provider has the statutory right to appeal an adverse decision like:
  - Coding
  - Medical Necessity
  - Prior Authorization
  - Gain Sharing/Risk Sharing
- DHS is limited to using technical deficiency for recoupment
  - Prohibits recoupment for minor omission (missing date or signature)(p.4/10)
  - Prohibits one denial from being used for subsequent denials without proving other claims are deficient (p.4/13)

AR Medicaid Fairness Act: A.C.A. § 20-77-1705

- DHS required to explain adverse decision in writing
- No recoupment for lack of medical necessity if service prior approved unless… (p.7/33)
- Presumption in favor of medical judgment of the treating physician on medical necessity. Any determination that the presumption is overcome must explain why. (p.8/17)

AR Medicaid Fairness Act: A.C.A. § 20-77-1709

- Rule may not be used against a provider unless they have been promulgated

AR Medicaid Fairness Act: Time Requirements for Audits

- Audit results must be submitted to provider within 150 days after completion of audit field work (p.8/36)
- Decision on reconsideration must be made within 60 days after reconsideration audit (p.9/3)
- Failure to meet time requirements results in no enforcement against provider (p.9/10)

AR Medicaid Fairness Act

- Absent fraud or danger to beneficiaries, provider allowed to seek an injunction to continue operating where DHS seeks to terminate (p.9/17)
- Provider Appeals to ALJ at ADH (p.4/35)
  - ALJ decision is final
  - Provider or DHS may appeal to court (p.6/7)