IN PARTNERSHIP WITH INDIANA FSSA & PARTICIPATING MANAGED CARE ORGANIZATIONS

Medicaid Provider Audit Toolkit

A Guide for Indiana Medicaid Providers

This communication provides important guidance to help your organization prepare for required Indiana Medicaid audits. Please review this document carefully. Timely and complete responses to documentation requests are required. Incomplete documentation requests will constitute a finding of overpayment.

WHY AUDITS MATTER	PROVIDER RESPONSIBILITY	TIMELY RESPONSES	NO CHARGE FOR RECORDS
Audits help ensure payments are accurate, appropriate, and supported by documentation.	**IHCP provider agreements require cooperation with federal and state officials during audits.**	**Submit requested records by the deadline identified in the audit notice.**	**Providers may not charge IHCP, MCOs, or business partners for audit records.**

As a reminder, your IHCP provider agreement requires you to fully cooperate with federal and state officials for periodic inspections, reviews, and audits. Please see IHCP bulletin (BT202626) which states you must do the following: To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits. At the discretion of the Office of Medicaid Policy and Planning (OMPP), failure to cooperate or promptly make available requested documentation can result in provider sanctions pursuant to 405 IAC 1-1.4-4, including suspension of payments, as well as exclusion from the Indiana Medicaid program for a period of up to three years. You may not charge the IHCP, including any of its managed care organization (MCO) or business partners, for providing records as part of any audit or review.

ABOUT AUDITS

Indiana Medicaid providers are required to participate in program and claims audits to ensure proper payments and the integrity of the Indiana Medicaid program.

The federal government, as majority payor, of Indiana Medicaid claims conducts routine and regular audits of Indiana Medicaid providers. You may receive notice of an audit from:

- Office of the Inspector General
- Department of Health and Human Services
- Center for Medicare and Medicaid Services
- Contractors for any of these entities

The State of Indiana is required by the federal government to ensure program and fiscal integrity of our payments. You may receive notice of an audit from:

- Office of Medicaid Policy & Planning (OMPP)
- Family & Social Service Administration Audit
- Office of the Attorney General
- Contractors for any of these entities

This toolkit is designed to help prepare for an audit. This toolkit is not intended to serve as the sole source of Indiana Medicaid Program requirements nor your rights and responsibilities.

Please refer to your Indiana Health Coverage Programs (IHCP) provider agreement, CMS requirements, MCO contracts as well as program reference materials, provider modules, provider bulletins and State and Federal laws and regulations.

THE AUDIT PROCESS

While specific timelines vary by auditor, the general process is as follows:

#	Step	What Happens
1	**Notification and records request**	Providers receive written notice identifying the audit scope, the claims under review, and the documentation required. Records may be requested by letter or retrieved onsite.
2	**Documentation submission**	Providers submit records to the contacts specifically outlined in the instructions requested by the entity.
3	**Initial review**	The auditor reviews submitted records against applicable requirements.
4	**Additional records request**	Auditors may request supplemental documentation, if applicable.
5	**Draft findings**	Providers receive preliminary findings and have an opportunity to respond.
6	**Reconsideration**	Providers may request reconsideration of draft findings within the timeframe specified by the auditor.
7	**Final findings**	The auditor issues final findings, including any overpayment calculation.
8	**Audit rights**	Providers retain all appeal rights as outlined in their IHCP provider agreement and applicable MCO contracts.

AUDIT CONTACT INFORMATION

If your practice is selected for an audit request from an MCO, you will be contacted directly, and guidance can be provided through the contact information outlined below. For additional contact resources, please refer to the IHCP Quick Reference Guide.

Audit Entity	General Questions
Anthem	anthem-indianaregulatory@anthem.com
CareSource	IN_Provider_Relations@caresource.com
Humana	INMedicaidProviderRelations@humana.com
MHS	mhsregulatorycompliance@mhsindiana.com
OMPP Program Integrity	ProgramIntegrity.FSSA@fssa.IN.gov
UnitedHealthcare	UHCINCompliance@uhc.com **or** IN_ProviderServices@uhc.com

DOCUMENTATION REQUIREMENTS

Due to the comprehensive scope of audits, the following documentation is required for all medical and behavioral health claims under review. All materials must be submitted to your MCO in a timely manner. The following is a list of required documents for all provider types and listed further below are specialized documentation needs. Your specific audit request will identify the exact documentation required for the claims under review.

GENERAL REQUIREMENTS

- Clinical, administrative, or financial records that substantiate medical necessity, appropriateness, billing, delivery, or monitoring of the service provided
- Physician/provider notes and Medication Administration Records (MAR), when applicable
- Physician orders; history and physical; progress notes; nursing and consult notes
- Discharge summaries, operative reports, and diagnostic test results
- Ancillary services, including radiology, ultrasound, CT scans, OT/PT, EKGs, etc.
- Prior authorization documentation and concurrent review records
- Medical staff credentials and signatures
- Provider background check documentation
- Care plans and individualized service plans
- Correspondence between ordering provider, rendering provider, subcontractor, and the Plan concerning the service

BEHAVIORAL HEALTH

- Required Initial Behavioral Health and/or Addiction Assessments or Reassessment (including the Child and Adolescent Needs and Strengths (CANS) Assessment and Adult Needs and Strength Assessment (ANSA) relevant for the date of service under review
- Treatment Plans, Individualized Integrated Care Plans (IICP), and/or Plans of Care (POC) for the relevant dates of service
- Group and Individual Therapy Notes
- Progress Notes or Summaries
- Psychiatric Diagnostic Evaluations
- Medication Monitoring and Prescriptions provided
- Daily Observation/Supervision/Nursing/Activity Log Notes (for Inpatient/Residential Programs)
- Transportation Log, if applicable
- Any other relevant documentation to support code(s) and modifier(s) billed on dates of service
- Roster of Providers and their Credentials (highest degree/field, licensure with dates)
- List of Office Location Addresses and Days/Hours of Operation

PATHWAYS WAIVER PROVIDERS

- Comprehensive Assessments
- Signed Plans of Care
- Notice of Action (NOA) LTSS
- Authorization Documents
- PASRR Results
- Interdisciplinary Team Notes

HOME HEALTH

- Attendant Time sheets
- Visit/Verbal Logs
- Home-Visit Summaries
- Electronic Visit Verification (EVV) Documentation

DME

- Invoices
- Delivery Tickets
- Proof-of-Delivery Receipts
- Equipment Serial Numbers
- Maintenance Logs
- Vendor Invoices
- Itemized Charge Sheets and Related Financial Documentation supporting the billed claim

REVIEW CRITERIA

Submitted documentation is reviewed against applicable standards, including Indiana Medicaid program requirements, OMPP provider modules, MCO policies, and state and federal law and regulation. Records that are missing, illegible, or insufficient to substantiate the service billed will be deemed a finding and will result in an overpayment determination. Reviewers evaluate medical necessity, appropriateness of care, billing accuracy, and documentation completeness.

SELF-DISCLOSURE

Providers are required to self-disclose identified overpayments or billing errors through the appropriate self-disclosure process before an audit has been initiated. Once an audit is initiated, providers are no longer eligible to self-disclose the claims under review; identified issues must be addressed through the audit process. For details on the self-disclosure process, refer to the Protocol for Voluntary Self-Disclosure of Provider Overpayments webpage or contact OMPP Program Integrity.