Long-Term Care Survey Alert

Compliance, MDS & Clinical Roundup

Get up to speed on Medicaid auditors, which experts say could be coming your way. For one, "the Medicaid Integrity Contractors (MICs) are still kicking around," says attorney **Paula Sanders,** with Post & Schell in Harrisburg, Pa. She's aware of one nursing facility that had a MIC audit and "it still can't figure out what the MIC is trying to determine."

A program resulting from the Affordable Care Act of 2010, says consultant **Nancy Beckley, MS, MBA, CHC,** "is the mandatory Medicaid RAC program. Each state Medicaid director must develop a Medicaid RAC program and hire a recovery audit contractor to basically do similar things as the Medicare RAC program." The programs will be run individually by each state, adds Beckley, principal of Nancy Beckley & Associates LLC**.**

A potential break: "The date by which the states were to have Medicaid RACs operational has been pushed back from April 1, 2011 indefinitely," says **Janice Potter, CPA, MAS,** healthcare research specialist at FR&R Healthcare Consulting in Deerfield, Ill. "A new implementation date will be included in the final rule for Medicaid RACs, when that is published," which is anticipated to occur later in 2011.

Up in the air: Sanders notes that while "Medicaid RACs are clearly on the horizon, the interplay between them and the MICs is unclear. Having Medicaid RACs could be duplicative for states that already have active Medicaid integrity programs."

You might keep an eye on New York, which has developed a reputation for having one of the tougher Medicaid compliance enforcement efforts. The New York Association of Homes & Services for the Aging members are seeing "very aggressive tactics by Medicaid auditors," says **Dan Heim,** president and CEO of the nonprofit trade group. "The investigations involve situations where an entire claim is deemed to be abusive and subject to recoupment for relatively minor paperwork errors or other issues (such as delays in getting doctors' signatures on documents) -- even though the underlying services were medically necessary and validly rendered.

This isn't occurring just in long-term care, but also in acute care, primary care, pharmacy and behavioral health," Heim tells Eli.

Fighting back: "Coalitions of providers have emerged to promote legislation that seeks to curb some of the practices the OMIG uses for its investigations and the basis on which claims are being denied," Heim reports.

The legislation, which was sponsored by both the state Senate and Assembly, didn't pass in 2010. But the bill did generate a lot of discussion during hearings held by the legislature, Heim reports. "We are ... making some modifications to the legislation and seeking to reinforce what we think was the original intent of the legislation that created the OMIG -- namely to focus on true fraud and abuse in the Medicaid program. If estimates of the level of fraud in the system are accurate, the OMIG could increase its recoveries by focusing on those areas," Heim says.

"We are cautiously optimistic that we will get provisions enacted into law this year that will refocus the OMIG's efforts on combating true fraud and abuse rather than trying to recover dollars from providers that have furnished services and may have made some small error or oversight in paperwork."

Wondering whether a resident coded on the MDS 3.0 as being on isolation for infection has to remain in his room? The answer is yes, according to information provided at the March 17 SNF/LTC Open Door Forum.

Facilities should "code only for isolation when a resident has a condition that is so serious that the resident is unable to leave his/her room and come in contact with any other resident," clarified a CMS' staffer during the forum.

The agency's **Sheila Lambowitz** further suggested that facilities look at their MDSs to ensure that they are coding

isolation appropriately.