



**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS



# LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS (DHH)

## RECOVERY AUDIT CONTRACTOR (RAC) AUDIT PROCEDURES AND PROTOCOLS

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DEDICATED TO GOVERNMENT HEALTH PROGRAMS



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## ■ Background

On January 17, 2013 the Contracts Supervisor for the Department of Health and Hospitals (DHH or Department) notified Myers and Stauffer LC (Myers and Stauffer) that DHH had executed the Recovery Audit Contractor (RAC) contract, effective January 1, 2013. The team of Myers and Stauffer healthcare professionals working on this contract is pleased to fulfill its responsibilities as Louisiana's Medicaid RAC for the purpose of ensuring the integrity of the Louisiana Medicaid Program.

As required by the RAC contract, Myers and Stauffer is responsible for developing a risk-based RAC work plan in coordination with the Department and subject to the Department's approval that will utilize various auditing approaches to maximize audit efficiency and focus resources on service areas that represent the greatest risk of mispayment. Myers and Stauffer, with the approval of the Louisiana Department of Health and Hospitals Program Integrity Section, has adopted the following general Audit Procedures and Protocols for the performance of audits under the RAC program. These Audit Procedures and Protocols may be revised and/or supplemented during the pendency of the RAC program.

## ■ General Methodology

Myers and Stauffer's core responsibility under the RAC Contract is to perform fraud, waste, and abuse-related audit reviews of Medicaid fee-for-service (FFS) payments to identify, verify, validate and recoup Medicaid overpayments and to identify, verify, validate and restore Medicaid underpayments. Louisiana Recovery Audit Contractor audits may involve reviews of payments for services by any, or all providers in any category of service (COS) provided under Louisiana's Medicaid program except for the exclusions discussed below. (A complete list of these Medicaid Covered Services may be found in the *General Information and Administration Provider Manual Chapter One of the Medicaid Services Manual* or contained within the Louisiana Administrative Code). As Louisiana's Medicaid RAC, Myers and Stauffer identifies audit issues or subjects in consultation with the Department and all Medicaid RAC audits are subject to the final approval of the Department.

The following claims are excluded from the RAC scope of review:

1. All claims processed or paid within 90 days of implementation of any Medicaid managed care program that relates to said claims. This shall not preclude review of claims not related to any Medicaid managed care program implementation;
2. Claims processed or paid through a capitated Medicaid managed care program. This scope restriction shall not prohibit any audits of per member per month payments from the department to any capitated Medicaid managed care plan utilizing such claims; and
3. Medical necessity reviews in which the provider has obtained prior authorization for the service.

Myers and Stauffer's general methodology for fulfilling this responsibility includes activities in the following areas:

### (a) Louisiana Medicaid Data Access and Storage

Myers and Stauffer receives, on a regular schedule, a data extract from Louisiana Medicaid's current Fiscal Agent Contractor (FAC), Molina Healthcare. Myers and Stauffer stores this data within a secure SQL Server data warehouse. Myers and Stauffer maintains Medicaid claims data with paid dates beginning January 1, 2009. Myers and Stauffer periodically receives claims data updates, as well as Medicaid member, provider, and other reference data. Myers and Stauffer reconciles the claims data to payment data to ensure that claims utilized in data analyses reflect accurate payments.



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(b) Selection of Audit Issues and Subjects

Myers and Stauffer develops audit subjects both internally, based upon its own audit experience and data analytics, and from a variety of other sources, including consultation with the Department and its Subject Matter Experts (SME), referrals from other government and private entities and additional resources.

Myers and Stauffer also receives referrals of audit subjects from various sources, including but not limited to: DHH; Louisiana Medicaid's Bayou Health MCOs; Louisiana Behavioral Health Partnership, which is managed by Magellan Health Services of Louisiana; the Louisiana Medicaid Fraud Control Unit (MFCU); the United States Department of Health and Human Services – Office of Inspector General; the Department of Justice; the Centers for Medicare and Medicaid Services (CMS); Medicare RACs; and other contractors, vendors and insurance companies performing health care audits.

Myers and Stauffer conducts extensive research into the laws, regulations and policies governing Medicaid reimbursements and consultations with SMEs and others to ensure that RAC audits of Medicaid claims are conducted under full and accurate guidance.

(c) Preliminary Review

After an issue or subject has been identified, Myers and Stauffer researches the applicable Medicaid policies and procedures and other sources of guidance, conducts a preliminary data analysis and obtains preliminary information about the providers to determine whether further review or an audit is warranted.

Preliminary data analysis includes the dollar amount and numerical volume of claims, number of providers, billing trends, potential overpayment or underpayment, and other data indices.

This stage of the review also includes preliminary information about any of the providers potentially subject to the audit, including but not limited to:

- (a) The length of time the provider has been enrolled in the Louisiana Medicaid program;
- (b) Whether the provider has been the subject of past audits by Myers and Stauffer, DHH or other auditing entities and whether any repayments or adverse actions resulted;
- (c) Whether the provider is under investigation by the Louisiana Medicaid Fraud Control Unit or any other investigative or law enforcement entities;
- (d) The number of locations the provider is operating;
- (e) Whether the provider's billing patterns represent outliers compared to other providers in the same category of service;
- (f) Whether there is any information suggesting the occurrence of improper billing or indications of fraud and/or abuse.

(d) Performance of Audits

Myers and Stauffer's RAC team, including auditors, analysts, coders, clinical reviewers and data analysts, under the direction of managers and a Medical Director, perform claims-based and complex desk audits, on-site audits, and validation of provider self-audits to identify and determine overpayments and/or underpayments. Myers and Stauffer uses its knowledge and experience with Medicaid policies and procedures, audits, various analytical tools, consultation



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with DHH and Subject Matter Experts (SMEs), research, and its monitoring of health care news and developments to identify mispayments.

(e) Recovery of Overpayments or Restoration of Underpayments

When potential mispayments (overpayments or underpayments) have been identified, Myers and Stauffer collaborates with the Department's Program Integrity Section and Office of Fiscal Management to notify providers of such determinations. Myers and Stauffer conducts discussions, informal administrative reviews of preliminary determinations upon request by providers, and provides expert witnesses at any subsequent appeal hearings. Myers and Stauffer also coordinates with the Department's Division of Fiscal Management to recover overpayments, either by provider payments or by recoupment from future Medicaid remittances.

Overpayments will not be recouped and underpayments will not be restored until all informal and formal appeals processes have been completed.

## ■ Types of Audits

When policy review, data analysis and provider information indicate that an audit should be performed, Myers and Stauffer performs a risk assessment for the purpose of determining what type of audit to perform. Such assessment includes consideration of other factors, including but not limited to:

- (1) The volume of claims and number of providers involved;
- (2) Whether it is possible to determine mispayments without the review of medical, financial or other records;
- (3) Whether the audit will involve issues of medical necessity and, if so, whether such issues can be addressed by Myers and Stauffer's medical director and/or clinical reviewers or whether additional specialized expertise will be required;
- (4) For audits requiring the review of medical, financial or other records, the level of expertise and credentials of any other reviewers required, and additional resources which may be required to complete the audit;
- (5) An estimate of the potential Return on Investment (ROI) if a specific type of audit is pursued.

If preliminary analysis, risk assessment and consultation with DHH indicate that an audit is warranted, Myers and Stauffer recommends performance of one of the following types of audits:

- (1) An "automated" review – a review of claims that does not include a review of medical or other records;
- (2) A "complex" desk review – a review of claims that includes a review of medical, financial and/or other records requested from the provider;
- (3) A "complex" onsite review – a review of claims that includes a review of medical, financial and/or other records obtained while Myers and Stauffer is onsite at the provider's location;
- (4) A "self-audit" - under appropriate circumstances, when mutually agreed to by the provider and Myers and Stauffer and with the approval of DHH, a preliminary "automated" or "complex" review may result in a request that a provider perform a provider "Self-Audit" in



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accordance with General Guidelines for Provider Self-Audits (see Appendix A for further information about such Guidelines);

- (5) A “Special audit” – a customized audit for reviews involving unique or complex issues.

### *Complex Audits Involving Clinical Issues*

(a) Scope

“Complex” audits include reviews of medical records for claims which raise utilization, medical necessity, levels of care and/or other clinical issues. While many of these reviews will involve hospital and physician services, other reviews may involve any of Louisiana Medicaid’s other categories of service, including but not limited to, services such as durable medical equipment (DME); physical, occupational and speech therapy; nursing home; hospice; psychological services; pharmacy; dental and others.

(b) Staffing of the Myers and Stauffer Louisiana Medicaid RAC Clinical Team

The Louisiana Medicaid RAC Clinical Audit Team consists of the Medical Director who oversees clinical reviews and staff in each of the following specialties: clinical reviewers who are Registered Nurses and/or Licensed Practical Nurses, Certified Professional Coders (CPC) and other Analysts with clinical and/or coding experience. Myers and Stauffer also contracts with medical specialists (e.g. Pediatric Endocrinologists) to ensure coverage of complex specialty practices and to allow for appropriate peer review of medical necessity cases. These personnel will make up the core of the Louisiana Medicaid RAC Audit Team’s clinical staff, who will also be assisted by other Louisiana Medicaid RAC team members, including auditors and data analysts.

In compliance with both Federal law and the Medicaid RAC Contract with the State of Louisiana, the Louisiana Medicaid RAC team will ensure that audits requiring a determination of medical necessity will be conducted by licensed, board certified or board eligible physicians of the appropriate specialty in medicine, osteopathy, dentistry or psychology who is licensed in the State of Louisiana.

(c) Guidance

Medicaid providers are responsible for complying with various sources of guidance applicable to claims submitted to the Medicaid program, including but not limited to: (1) Federal and State law and regulations; (2) Louisiana Medicaid policies, including General Information and Administration policies applicable to all enrolled providers and supplemental chapter policies applicable to specific categories of service; (3) Medicaid policies included in the Louisiana Administrative Code; (4) professional standards; and (5) coding guidelines, including the Current Procedural Terminology, (CPT) 2012, Professional Edition, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), and the HCPCS Level II. The editions of these publications which were in effect at the time of the date of service will be utilized in the clinical reviews.

Some of the core guidelines mandated by the Medical Assistance Program Integrity Law as set forth in Section 1.1, *General Information and Administration Chapter One of the Medicaid Services Manual*, applicable to all Medicaid providers include, but are not limited to the following requirements:

- Comply with all federal and state laws and regulations;



- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- Maintain all necessary required licenses or certificates;
- Allow for inspection for all records by governmental authorities, including but not limited to, DHH, the State Attorney General's MFCU, and the Department of Health and Human Services;
- Safeguard against the disclosure of information in the recipient's medical records;
- Bill other insurers and third parties prior to billing Medicaid;
- Report and refund any and all overpayments;
- Agree to be subject to claims review;
- Allow inspection of the facilities.

Supplemental chapters of the policy manual and the Louisiana Administrative Code set forth additional requirements for specific categories of service.

Professional standards of practice and evidence based guidelines have been developed by research and government organizations such as: the United States Preventive Services Task Force; the National Institutes of Health (NIH); Centers for Disease Control and Prevention (CDC); World Health Organization (WHO); *Agency for Healthcare Research and Quality (AHRQ)*; and various physician specialty associations including the American Academy of Family Physicians; the American College of Physicians; the American College of Emergency Physicians; the American College of Cardiology; the American Academy of Allergy, Asthma & Immunology; the American College of Radiology; the American Society of Nephrology; and others. These guidelines and standards of practice may be applicable to certain types of audits.

Under the supervision of the Medical Director, the Louisiana Medicaid RAC clinical team will draw from these sources and others, including current peer-review journals and peer-reviewed and/or edited specialty textbooks to determine the clinical criteria applicable to a specific audit. The team will also utilize InterQual™ clinical guidelines and software to determine the propriety of utilization, medical necessity, level of care and documentation.

#### (d) Requests for Medical Records

##### (1) Generally

The scope of the clinical review and the number of records requested and reviewed will vary dependent upon the audit issues presented. For example, the review for a simple drug screen will involve a much more focused review than would the review of a major surgical procedure.

The clinical team, under the direction of the Medical Director, will determine the scope of the clinical review and parameters of the record request when the audit plan is finalized. Every effort will be made to limit requests for records to those which are necessary to complete the specific review.

The general guidelines for request for records and submission of records will apply to clinical reviews. However, when voluminous records are requested, the Louisiana Medicaid RAC has the authority to extend the 45-day production period, if necessary, upon a provider's request.

##### (2) Limitations on the Number and Frequency of Medical Record Requests



For the purposes of establishing limitations on the number and frequency of medical records that can be requested for a Louisiana Medicaid RAC audit, “one medical record” is defined as all medical documentation for one Medicaid member’s continuous episode of treatment performed at one location. For example, hospital records for a member’s two-week inpatient treatment would constitute “one medical record”, as would the medical chart notes for a brief office visit to a physician, which could span multiple dates of service.

The limitation on the number and frequency of medical record requests applies to each of a provider’s servicing provider numbers (not payee numbers). Therefore, if a provider performs services at multiple locations, the limitation applies to each location. In the event that one or more providers under the same Tax Identification Number (TIN) receive concurrent Medicaid RAC medical record requests, Myers and Stauffer will work with providers to develop a reasonable schedule for production of records.

The numerical limit is based on the number of a provider’s Medicaid claims during the prior state fiscal year, without regard to the type of claim.

The frequency limitation is based on the number of requests made within a 90-day time frame.

The Louisiana Medicaid RAC team may request from a provider a number of records every 90 days not to exceed the lesser of: (1) one percent of the total number of Medicaid claims submitted by the provider during the previous state fiscal year per Servicing Provider Number; or (2) not to exceed 200 medical records every 90 days.

(e) Performance of a Clinical Review

The Louisiana Medicaid RAC clinical team will review Medicaid claims to determine if such claims were properly paid based upon the guidance determined to be applicable to the services billed by the provider(s).

The issues presented in specific audits will vary, but may include issues such as:

- Were the services performed and delivered in compliance with all applicable Louisiana Medicaid Policies?
- Were the services not requiring prior authorization for which claims were submitted and reimbursed medically necessary?
- Did the services meet accepted professional standards and/or evidence-based clinical guidelines?
- Were any claims submitted for services that were not performed or documented?
- Were claims submitted for services that were over utilized, on the basis of applicable guidelines, standards, or references?
- Were claims submitted for services that were performed in excess of any applicable policy limitations on the number of units, items or services during certain periods of time?
- Were any errors or amendments in patient records corrected in compliance with currently accepted standards of medical practice?



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- Were the services billed under the procedure code(s) which most nearly describes the procedure(s) performed?
  - Was the number of units billed equal to the documented units of service performed?
  - Was there clinical support for the frequency, duration, and amount of the billed services or items?
  - Was the use of coding modifiers appropriate for the services performed?
  - With respect to physician office visits, did Evaluation and Management services meet the criteria corresponding to the levels of service actually performed?
  - Was appropriate oversight both demonstrated and documented for services provided by physician extenders?
  - Were physician orders entered and signed when required for the services and treatment performed and billed?
  - Were the technical and professional components of radiological services properly billed?
  - With respect to hospital services, did member patients meet criteria for observation vs. admission?
  - With respect to hospital inpatient services, were the diagnoses, procedures, and other factors that impact the total charges appropriate, valid for the treatment performed, and correctly documented within the medical record?
  - With respect to surgical procedures, were services properly included or excluded from the bundled global surgery fee?

Following the review of claims and the medical records by the Louisiana Medicaid RAC team, the team will determine whether any potential overpayments or underpayments to the Medicaid provider(s) occurred. Myers and Stauffer will send an Initial Findings Letter to the audited providers and thereafter the general audit process will be followed.



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## ■ Processes and Procedures

### *Performance of Audits*

#### (a) Obtaining and Reviewing Medical, Financial and Other Records

For a complex audit involving a review of medical, financial and/or other records, a Request for Records will be sent to a provider and that provider will have forty-five (45) calendar days from the date of receipt of the Request to provide the documentation. In audits involving complex or voluminous records, Myers and Stauffer will work with providers to ensure a reasonable production process which is not unduly burdensome to providers.

Providers are encouraged to produce records in electronic format, including imaged records on CD/ DVD. Upon request of a provider, Myers and Stauffer will accept a provider's submission of electronic medical records on CD/DVD, via the Myers and Stauffer secure file transfer protocol (SFTP) portal, via Secure e-mail, or via facsimile. Electronic records should meet the following requirements:

- (1) Scanned images must be at least 200 dpi and in black and white. Color is also acceptable;
- (2) Multipage documents must be in one image; e.g. a ten-page document should be provided as one imaged file;
- (3) Data should be stored in a Database or Excel file format, or otherwise provided in a fixed format sequential file in ASCII;
- (4) All data and records should be clearly labeled and include the provider's name, Medicaid number, date and Myers and Stauffer tracking number;
- (5) Myers and Stauffer will accept electronic data by Flash drives, compact disks, secure electronic transfers, or via facsimile.

For the purpose of ensuring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and all other privacy and confidentiality laws, regulations and policies, Myers and Stauffer will offer and instruct providers on the use of SFTP transmission and will create SFTP accounts for providers who request an account be established for audit record submission purposes.

Providers who use electronic health records (EHR) may be asked, in appropriate circumstances, to produce copies of their policies which: (a) define how access to the records is granted and monitored; (b) how entries and updates to the EHR are logged and tracked; and (c) how electronic signatures within the EHR are validated.

Providers must notify Myers and Stauffer prior to submitting paper records. If Myers and Stauffer requires a provider to produce records in a non-electronic format, MSLC shall make reasonable efforts to reimburse the provider the cost of medical records reproduction consistent with the provisions of 42 CFR 476.78. In no circumstance shall the reimbursement rate exceed the rate under the Louisiana statutes for public record requests. Reasonable costs as defined above incurred for non-electronic RAC record production may be applied as a credit against any overpayment or as a reduction against any underpayment identified. Providers must ensure that copies are of good quality and one-sided only, and that papers



are free of staples, paperclips and other fasteners. Providers are encouraged to number records by Bates stamp or similar method.

Myers and Stauffer will receive, maintain and transmit all medical records in compliance with HIPAA, HITECH and other Federal and State privacy and confidentiality laws and regulations.

Providers must also ensure that the transmission and production of records comply with all such applicable laws, regulations and policies.

(b) Review Procedures

Pending receipt of records, Myers and Stauffer will develop an audit methodology, including appropriate audit checklists and/or other work papers to be used in Desk Reviews, On-site Audits, or Special Audits.

Following production of the medical, financial or other records, Myers and Stauffer will complete its review and issue an Initial Findings Letter within sixty (60) calendar days of receipt of all requested materials from a provider. The Initial Findings Letter will include one or a combination of the following determinations:

- (1) Claims were properly paid;
- (2) Claims were potentially overpaid, based on specific policy violations or other appropriate criteria utilized in the review, resulting in a proposed recoupment;
- (3) Claims were underpaid, resulting in a proposed additional payment to the provider.

The Initial Findings Letter will typically include a claims discrepancy table which provides additional details about claims reviewed.

(c) Referral of cases involving suspected fraud and/or abuse

When in the course of selecting claims for audits, or during the performance of an audit, Myers and Stauffer becomes aware of information indicating suspected fraud and/or abuse, Myers and Stauffer will promptly refer such information to the Department of Health and Hospitals Program Integrity Section. Myers and Stauffer will meet quarterly with the Medicaid Fraud Control Unit to coordinate audits with the Program Integrity Section and the Medicaid Fraud Control Unit.

(d) In the event of a finding of an overpayment, a provider may:

- (1) Accept the findings, in whole

A provider should not submit an adjusted claim, void a claim or remit payment during the pendency of any audit unless or until instructed to do so. The Final Decision letter will contain important information for tracking repayments and accounting.

- (2) Accept or disagree with the findings, in whole or in part, and request an informal discussion

Beginning on the date of issuance of any initial findings letter by Myers and Stauffer, there shall be an "informal discussion" and consultation period. During this period the provider and Myers and Stauffer may communicate regarding any audit determinations.



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(3) Request Informal Hearing

Within forty five (45) calendar days of receipt of written notification of an adverse determination from the contractor, a provider shall have the right to request an informal hearing relative to such determination. DHH Program Integrity shall be involved in this hearing. Any such request shall be in writing and the date of receipt shall be deemed to be two days after the date of the adverse determination letter. The informal hearing shall occur within thirty (30) days of the provider's request. At the informal hearing the provider shall have the right to present information orally or in writing, the right to present documents, the right to have DHH and the RAC contractor address any inquiry the provider may make concerning the reason for the adverse determination. A provider may be represented by an attorney or authorized representative at the informal hearing if written notice of representation is submitted with the written request for informal hearing. The contractor and DHH Program Integrity shall issue a final decision related to the informal appeal to the provider within fifteen days of the closure of the hearing

(4) Request Formal Administrative Appeal

Within thirty (30) days of issuance of a final decision or determination pursuant to an informal hearing a provider may request an administrative appeal of the final decision by requesting a hearing before the Division of Administrative Law. A copy of the request must be filed contemporaneously with DHH Program Integrity.

Requests for hearings should be made in writing and explain the reason for the request and the basis upon which the provider disagrees with the results of the informal hearing. All requests for an Administrative Appeal should be sent to:

**Division of Administrative Law – HH Section  
Health and Hospitals Section  
P.O. Box 4189  
Baton Rouge, LA 70821-4189  
Phone: (225) 342-0443  
Facsimile: (225) 219-9823**

In accordance with DHH policies and procedures, providers must also send a copy of the request for appeal to:

**Department of Health and Hospitals  
Program integrity Unit  
Bienville Building  
P.O. Box 91030  
Baton Rouge, LA 70821-9030**

A provider may choose to forego the Informal Hearing and request an Administrative Appeal within (30) days after receipt of the initial findings letter.

The Program Integrity Section will notify Myers and Stauffer of the request for an Administrative Appeal. In such cases, Myers and Stauffer will provide expert witnesses to testify at the Administrative Law hearing.

- (e) In the event that a provider fails to respond to the Initial Findings Letter, Myers and Stauffer will request DHH's Division of Fiscal Management to set up an Accounts Receivable in the amount of the overpayment and recovery will be recouped from future provider remittances.



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- (f) Prior to the issuance of any letter or notice to a provider, Myers and Stauffer requests that the DHH Division of Fiscal Management assign a Benefit Recovery Control Number to each provider who is a subject of the audit. Myers and Stauffer submits the form of all provider letters or notices to the DHH Program Integrity Director for approval.

## ■ Other Audit Issues

- (a) Time period for audits

Initial reviews had a “look back” period of up to five years because the Department of Health and Hospitals received an exemption from the Centers for Medicare and Medicaid Services (CMS) to allow a “look back” period of up to five years. For reviews initiated after November 20, 2014, the “look back” period will be three years from the date of the initial payment. The “look back” period begins the date the relevant audit is initiated.

- (b) Use of statistical sampling and projection

Subject to the approval of DHH and on a case-by-case basis, Louisiana Medicaid RAC audits may in appropriate circumstances use statistically valid sampling and extrapolation to determine amounts of overpayments. If approved, such process will be conducted after consultation with and upon the advice of a qualified statistician and using generally approved statistical software, such as the HHS-OIG’s RATS-STAT.

- (c) Coordination of audits

In consultation with DHH’s Office of Program Integrity, Myers and Stauffer coordinates with other auditing entities to avoid duplicative audits which may be burdensome on providers. Myers and Stauffer will meet monthly with the Program Integrity Section. At quarterly intervals unique to each interested party, these monthly meetings will include representatives from other audit entities, such as the Medicaid Fraud Control Unit, the Bayou Health managed care plans, and others as needed. The Program Integrity Section will coordinate the inclusion of other audit entities at the monthly meeting with Myers and Stauffer. A provider who receives notice of a Louisiana Medicaid RAC audit which appears to duplicate a completed or pending audit should notify Myers and Stauffer via toll-free number or in writing. Audits which address different services, issues, claims or time periods are not considered duplicative.

## ■ Work Breakdown Structure

Myers and Stauffer’s Louisiana Medicaid RAC Team will consist of management and non-management staff. Management of the RAC contract and oversight of this RAC Project will be performed by Myers and Stauffer’s Louisiana RAC management team, consisting of the Project Directors, Project Manager, and Medical Director. The Myers and Stauffer management team has more than fifty years of health care auditing/program integrity experience, has a thorough understanding of the Medicaid program, and offers a unique combination of audit, medical, and project management skills. The day-to-day RAC audit work will generally be performed by Myers and Stauffer Senior and Staff Analysts with experience performing

- Medicaid audits
- Fraud investigative and audit work
- Data analytics
- Clinical reviews



Professional credentials and certifications maintained by the management team and non-management team include, but are not limited to:

- Certified Public Accountants (CPA)
- Certified Fraud Examiners (CFE)
- Masters in Business Administration (MBAs)
- Doctor of Medicine (MD)
- Registered Nurses (RN)
- Licensed Practical Nurses (LPN)
- Certified Professional Coders (CPC)

Myers and Stauffer has nineteen (19) offices with over 700 staff, including specialists (for example pharmacists and attorneys) who are available on an “as needed” basis to provide audit, consultation, and technical support.

Myers and Stauffer’s complex audits involving clinical reviews will generally be performed by the RAC Clinical Team; however, for audits requiring such specialized knowledge, Myers and Stauffer will utilize on an “as needed” basis, medical consultants, including physicians or other healthcare specialists. Myers and Stauffer has consulted with a peer review organization which provides experts for determining medical necessity issues and analytics in healthcare audits, and has in place an arrangement to engage specialist reviewers when such need arises.

## ■ Provider Education and Outreach

### (a) Toll-free Number

Myers and Stauffer has established a dedicated Louisiana RAC toll-free number that is staffed by trained personnel and available Monday through Friday, 8:00 AM to 4:30 PM, Central Time. The Louisiana RAC toll-free number is (855) 817-3086.

### (b) Louisiana Medicaid RAC Website

Myers and Stauffer has created a Louisiana RAC Website (<http://LouisianaMedicaidRAC.mslc.com>) to promote provider education and outreach and has made available on this site a list of “Frequently Asked Questions” about the Louisiana RAC program. Additional updates and news about Louisiana RAC are added to this site on an ongoing basis.

Myers and Stauffer has also created a Louisiana Medicaid RAC quick response (QR) code that can be appended to provider letters or other documentation. The QR code allows providers or other interested parties to scan the QR code with a QR reader and access the Louisiana Medicaid RAC website quickly. The QR code is:





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(c) Points of Contact

To meet the Federal requirement that a Medicaid RAC “compile and maintain provider approved addresses and points of contact”, Myers and Stauffer developed a “point of contact” form which is available on the RAC website and will enable providers to designate personnel who will serve as their “points of contacts” for RAC audits and news and developments.

(d) Other Provider Education and Outreach Activities

Myers and Stauffer’s RAC management team has reached out to professional associations to inform the provider community about the RAC program and will continue to do so as part of the annual Project Plan.

## ■ Coordination of Audit Activities

Both the RAC Contract and Federal law require that Myers and Stauffer coordinate and communicate with DHH and other state and federal audit contractors so as not to duplicate audit activities. Myers and Stauffer has been engaged in ongoing discussions with DHH Program Integrity to develop a schedule of meetings to ensure coordination with such entities, which include the following: the Louisiana Medicaid Fraud Control Unit (MFCU), AdvanceMed (which serves as the Zone Program Integrity Contractor (“ZPIC”) for Louisiana), the current Managed Care Organizations offering Prepaid Plans and Shared Savings Plans which service Louisiana’s Medicaid program.

## ■ Training

To fulfill its contractual obligation to “provide other staff with appropriate training and experience to perform the services required under [the] Contract”, Myers and Stauffer has implemented a training program for staff on the Louisiana RAC contract. This includes, for example, a Myers and Stauffer in-house RAC fraud-related training which occurred September 4 through 6, 2012. As additional staff join the Myers and Stauffer RAC team the in-house training will be updated and repeated on “as needed” basis.

In addition, Myers and Stauffer sends staff to various program integrity training sessions and conferences. Several RAC staff that will be working on the LA RAC contract attended the National Association for Medicaid Program Integrity (NAMPI) conference annually.

As part of the Project Plan, Myers and Stauffer continues to develop RAC in-house training opportunities and will also send staff to external training programs to ensure that Myers and Stauffer’s RAC personnel are fully trained on various RAC subjects and issues.

## ■ Case Tracking

Myers and Stauffer developed and maintains a proprietary case tracking system called the Audit Case Tracking (ACT) system. This system will be utilized by Myers and Stauffer for Louisiana RAC purposes and reporting access will be provided to the DHH as part of the RAC engagement.



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## ■ Appendix A: General Guidelines for Provider Self-Audits

In certain circumstances subsequent to a preliminary “automated” claims review or at any time during a complex review, Myers and Stauffer LC (Myers and Stauffer) may, after consultation with and the approval of the Department of Health and Hospitals (DHH), request that a provider perform a self-audit. The self-audit must be mutually agreed to by the provider and Myers and Stauffer and will be performed in accordance with the following procedures:

1. Myers and Stauffer will issue to the provider a Request for Self-Audit letter that will include, at a minimum, the following information:
  - (a) Identification of the types of claims to be reviewed, time period of such claims, total number of claims and total dollar amount paid by Medicaid for such claims;
  - (b) A summary of the issues raised by the audit to date and identification of the policies and procedures which apply to the claims at issue;
  - (c) A sampling plan developed by Myers and Stauffer or, at the discretion of Myers and Stauffer, a request for the provider to develop and propose its own sampling plan. A sampling plan should include the total number of claims to be reviewed, the methodology for reviewing such claims, whether or not a statistically valid sample and projection will be utilized, a description of the credentials of the reviewer(s), and an estimate of the time needed to complete the audit.
2. Approval of the Self-Audit Plan is at the sole discretion of Myers and Stauffer and may not proceed without the written approval of Myers and Stauffer. In the event that a provider declines to perform a Self-Audit, then Myers and Stauffer may proceed with its own audit or review of the provider’s claims.
3. Following approval of the Self-Audit Plan, a provider shall perform the Self-Audit and report the results in writing to Myers and Stauffer within the time limit noted within the Self-Audit notification. With respect to complex or lengthy audits, Myers and Stauffer may request periodic progress reports, copies of work papers, or other documentation used in the provider’s Self-Audit.

### 4. Corrective Action

The appropriate management of the audited provider should review the audit findings to ensure that changes will be made in policies and procedures to correct future errors involving the same issues raised by the audit. For all errors identified, a corrective action plan must be submitted to Myers and Stauffer and to the DHH Program Integrity Section.

### 5. Validation

Following completion of the provider Self-Audit, Myers and Stauffer will typically validate the audit results by reviewing some or all of the claims and documentation reviewed by the provider, or additional claims not reviewed by the provider. In appropriate circumstances Myers and Stauffer may accept the results of the Self-Audit without validation, though this is expected to be rare. Finally, in some circumstances Myers and Stauffer may reject the results of the Provider Self-Audit and initiate alternative audit procedures, including, at the discretion of Myers and Stauffer and in consultation with the DHH, an on-site audit.



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6. Findings

Following submission of the provider's report of the Self-Audit and the conclusion of validation of the Self-Audit by Myers and Stauffer, Myers and Stauffer will issue an Initial Findings Letter to the provider.

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