Network Provider Audit

What is the purpose of OIG network provider audits?

Health Maintenance Organizations (HMOs) are contractually obligated to ensure program integrity within their provider network. The Office of the Inspector General (OIG) conducts audits to determine the effectiveness of the HMOs' oversight, as well as to provide additional monitoring for fraud, waste, and abuse.

What is OIG's audit criteria?

OIG will audit to ensure the:

- Actual provision of the service can be verified.
- Service was appropriate.
- Claim was accurate.

What is the audit process?

- OIG requests records from the provider.
- OIG reviews the records in accordance with Medicaid laws and regulations.
- OIG sends a preliminary letter and report.
- Providers may submit rebuttal.
- OIG reviews rebuttal submitted by the provider.
- OIG sends a final letter, report, and technical assistance.

How will OIG address findings discovered in network provider audits?

Once a provider receives the final letter and report from OIG, their work with OIG is done. OIG sends a final audit letter and a final report to the respective HMOs.

How do the HMOs address findings discovered in network provider audits?

HMOs will complete the following steps per their contract:

- Work with you to correct the findings in your audit.
- Work with all providers within the network to ensure future audits do not contain the same findings.
- May choose to recover the actual overpayments.

How can the network provider respond to the HMO's actions?

If the HMO chooses to recover the overpayment from the network provider, the network provider can appeal the action by following the appeals process outlined in their contract with the HMO.

What is an overpayment?

An overpayment* is the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished.
*42 CFR 433.304

Will OIG collect the identified overpayment?

No. The HMO has the authority to seek recoupment of overpayments.

Will OIG take any additional action?

In addition to following the described audit process, OIG can take any combination of the following actions:

- Refer to the Department of Justice — Medicaid Fraud Control and Elder Abuse Unit (credible allegations of fraud) for investigation.
- Refer to the Department of Safety and Professional Services (professional standards) for investigation.
- Impose sanctions.
- Terminate your participation in Medicaid program.

Report fraud, waste & abuse via the fraud hotline at 877-865-3432 or www.reportfraud.wisconsin.gov

How can I work with OIG to ensure that I have a successful audit?

- Submit all of the documents requested by OIG within the specified time frame.
- If you need additional time, please contact the assigned auditor using the contact information in the records request letter to discuss an extension.
- Review the preliminary letter and report(s) and submit rebuttal documentation within the specified time frame.
- If you agree with OIG's findings, please let your auditor know.
- Review the final audit letter and report(s).
- Comply with all Medicaid laws and regulations as well as any additional requirements that are part of your contract with each HMO.

How can I work with the HMOs to ensure that audit remediation is successful?

- Respond to requests for information from your HMO(s).
- Follow instructions provided by the HMO(s) to correct your specific findings (where possible).
- Follow instructions provided by the HMO(s) to ensure these findings do not appear in future audits across the network.
- Return overpayments as directed by the HMO(s), if applicable.
- Comply with all Medicaid laws and regulations as well as any additional requirements that are part of your contract with each HMO.

What happens if I have another audit that identifies the same findings?

Each HMO has their own contract with you that identifies steps that can be taken to address performance issues. OIG may engage with the HMOs in the following ways:

- Impose a corrective action plan on the HMO
- Impose a financial sanction on the HMO
- OIG will consider whether the findings are egregious or repetitive when addressing these issues with the HMOs