

Program Integrity

Be Aware of
Medicaid Fraud

Nevada Medicaid and Nevada Check Up with HPES

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Today's Topics

- Program Integrity
- Surveillance and Utilization Review (SUR)
- Examples of SUR Cases
- Impact on Providers
- Corrective Actions
- Medicaid Fraud Control Unit (MFCU)



Program Integrity – Medicaid Services Manual (MSM) Chapter 3300

The Division of Health Care Financing and Policy (DHCFP) is responsible for the fiscal integrity of the Medicaid and Nevada Check Up programs and is committed to a program that identifies and reduces fraud, abuse and improper payments. The DHCFP must ensure Medicaid and Nevada Check Up recipients have access to quality care and claims are paid appropriately and in accordance with state statutes and federal laws and regulations, program policies and billing manuals.



Program Integrity

The DHCFP has three distinct programs to assist in ensuring the fiscal integrity of the programs it administers:

- Surveillance and Utilization Review (SUR) program
- Payment Error Rate Measurement (PERM) program
- Financial and Compliance Audit program

❖ See Medicaid Services Manual (MSM) Chapter 3300



Surveillance and Utilization Review (SUR)

- Statewide program to safeguard against unnecessary or inappropriate use of services
- Prevent excess payments in an efficient, economical and effective manner
- Develop statistical provider profiles
- Analyze claims data to identify potential fraud, waste, over-utilization and abuse
- Collect provider overpayments and refer appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution
- A Fair Hearing process is available to dispute actions by SUR



SUR Investigation Process

Conduct investigations of potential fraud and abuse based on complaints, referrals and through the use of fraud detection and other analysis

- Referrals are received from various sources:
 - Via email, phone or letter
 - Tips received from other governmental entities
 - Concerns reported by Medicaid District Offices, Central Office or HP Enterprise Services
 - Cases from other states and the Office of the Inspector General are reviewed regularly to determine future projects



SUR Investigation Process, continued

Investigations include:

- Policy review
- Claim payment review
- Review of outliers:
 - Spikes in payment for certain provider types
 - High use of specific codes
 - Review of high-risk claims (provider types known for fraudulent practices)
 - Review of procedures/codes paid at a percentage of billed charges



Payment Error Rate Measurement (PERM)

- The Improper Payments Act of 2002 (IPIA) requires the Centers for Medicare & Medicaid Services (CMS) to estimate improper payments in all state Medicaid and State Children's Health Insurance Programs (Nevada Check Up)
- CMS requires each state to undergo a PERM review once every three years
- Nevada was reviewed in federal fiscal year 2011 and will be reviewed every third year thereafter



Payment Error Rate Measurement (PERM), continued

- PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation
- Recipient eligibility reviews will be conducted by the Division of Welfare and Supportive Services (DWSS)
- The claims processing and medical record or service documentation reviews for the mandated PERM program will be conducted by federal contractors



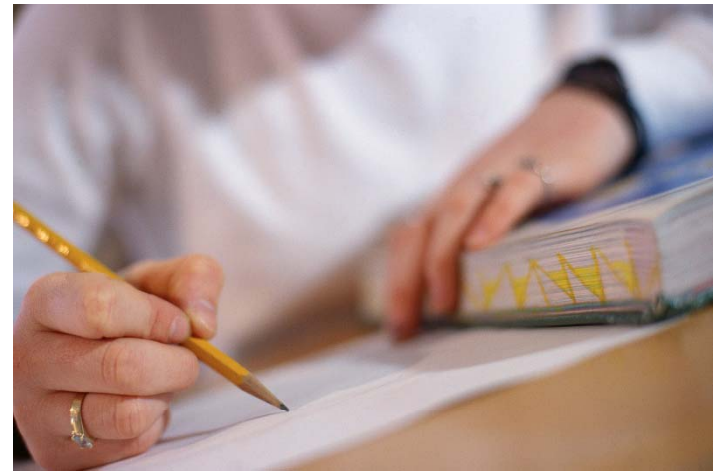
Financial and Policy Compliance Audits

- DHCFP will conduct regular financial and policy compliance audits of programs and services provided under the Medicaid and Nevada Check Up programs
- These audits consist of a thorough review of program policy, claims processing and/or medical or service record documentation



Learning Check

1. What are the three programs DHCFP has to ensure the fiscal integrity of the Nevada Medicaid program?
2. True or False – Each state is required to undergo a PERM review annually
3. What does SUR stand for?



Definitions



Abuse – MSM 3302.1

Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices, and result:

- in an unnecessary cost to the Medicaid or Nevada Check Up programs, or
- in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.

It also includes recipient practices that result in unnecessary cost to the Medicaid or Nevada Check Up programs. (42 Code of Federal Regulations (CFR) 455.2)



Administrative Action – MSM 3302.2

Administrative Action is an action taken by the DHCFP that includes but is not limited to:

- Recovery of improper payments
- Issuance of educational letters
- Issuance of warning letters
- Issuance of recoupment/recovery letters
- Special claims reviews or on-site audits
- Requests for provider corrective action plans
- Requests for provider self audits



Administrative Action – MSM 3302.2 (Continued)

- Referral to appropriate civil agencies (licensing bodies)
- Referral to the MFCU
- Denial of provider applications
- Suspension and termination of provider status
- Other actions as stated in policy MSM 3303.3A
 - ❖ DHCFP may impose special requirements on providers as a condition of participation



Fraud – MSM 3302.3

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)



Improper Payment – MSM 3302.4

An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with:

- The Medicaid or Nevada Check Up policy governing the service provided
- Fiscal agent billing manuals
- Contractual requirements
- Standard record keeping requirements of the provider discipline
- Federal law or state statutes



Examples of improper payments

Improper payments include but are not limited to:

- Improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits
- Overpayment/Underpayment
- Payments for ineligible recipients
- Payments for ineligible, non-covered or unauthorized services
- Duplicate payments
- Payments for services that were not provided or received
- Payments for unbundled services when an all-inclusive bundled code should have been billed



Examples of improper payments, continued

- Data entry errors resulting in incorrect payments
- Payments where the incorrect procedure code was billed (up-coding)
- Payments over Medicaid allowable amounts
- Payments for non-medically necessary services
- Payments where an incorrect number of units were billed
- Submittal of claims for unauthorized visits
- Payments that cannot be substantiated by appropriate or sufficient medical or service record documentation
- Improper payments can also be classified as fraud and/or abuse
- Payments not in accordance with applicable pricing or rates



Kickbacks – MSM 3302.5

- The offering or receiving of any payments or incentives by/from a provider for referring patients, including illegal cash reimbursements, vacations, merchandise, or personal services. (Nevada Revised Statutes (NRS) 422.560)

Overpayment/Underpayment – MSM 3302.6

- This is an amount paid by the DHCFP, to a provider, which is, in excess of or less than, the amount that is allowable for services furnished under applicable policy, rate or regulation



PERM Review Errors – MSM 3302.7

- These are payment errors discovered during the course of PERM medical record, data processing or eligibility reviews

Recoupment/Recovery – MSM 3302.8

- Recoupment or recovery is an administrative action by the DHCFP or its fiscal agent to initiate re-payment of an overpayment, with or without advance official notice. Recoupment or recovery can be made by reducing future payments to a provider or by direct reimbursement from the provider



Unbundling – MSM 3302.9

- Unbundling is the billing of separate procedure codes rather than one all-inclusive code, when an all-inclusive code is required to be billed

Up-Coding – MSM 3302.10

- Up-coding is billing using procedure codes that overstate the level or amount of health care or other service provided



Identification of Fraud, Abuse and Improper Payments



Policy – MSM 3303.1

The DHCFP has methods and criteria to identify and track suspected cases of fraud, abuse and/or improper payments. These methods or criteria must not infringe on the legal rights of persons involved; must afford due process of law; and must comply with federal law and state statutes



Coverage and Limitations - MSM 3303.1A #2

Fraudulent acts, false claims or abusive billing practices include, but are not limited to:

- Submitting a claim or causing a claim to be submitted, knowing the claim to be false, in whole or in part, by commission or omission
- Making or causing to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission
- Submitting a false application for provider status
- Submitting repeated claims from which required information is missing or incorrect
- Submitting a claim for medically unnecessary services

❖ For complete listing, see MSM Chapter 3330, Section 3303.1A



Provider Responsibility – MSM 3303.1B

- Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers
- Providers must adhere to:
 - DHCFP policy
 - Provider services and operations manuals
 - Fiscal agent billing manuals
 - All applicable federal law and state statutes
 - Any other guidance furnished by the DHCFP or their fiscal agent regarding provider requirements and responsibilities



Examples of SUR Cases and Impact on Providers



Data Mining Software

- DHCFP is in the process of implementing data mining software that will show outliers from their peers
- This software, among other things, will show high utilization, procedures that should be bundled, high modifier usage and other areas of possible fraudulent billings



SUR Staffing

- State Fiscal Year 2007 there were three positions
- State Fiscal Year 2008 the unit was increased to ten positions
- State Fiscal Year 2012 the unit was increased to fourteen positions

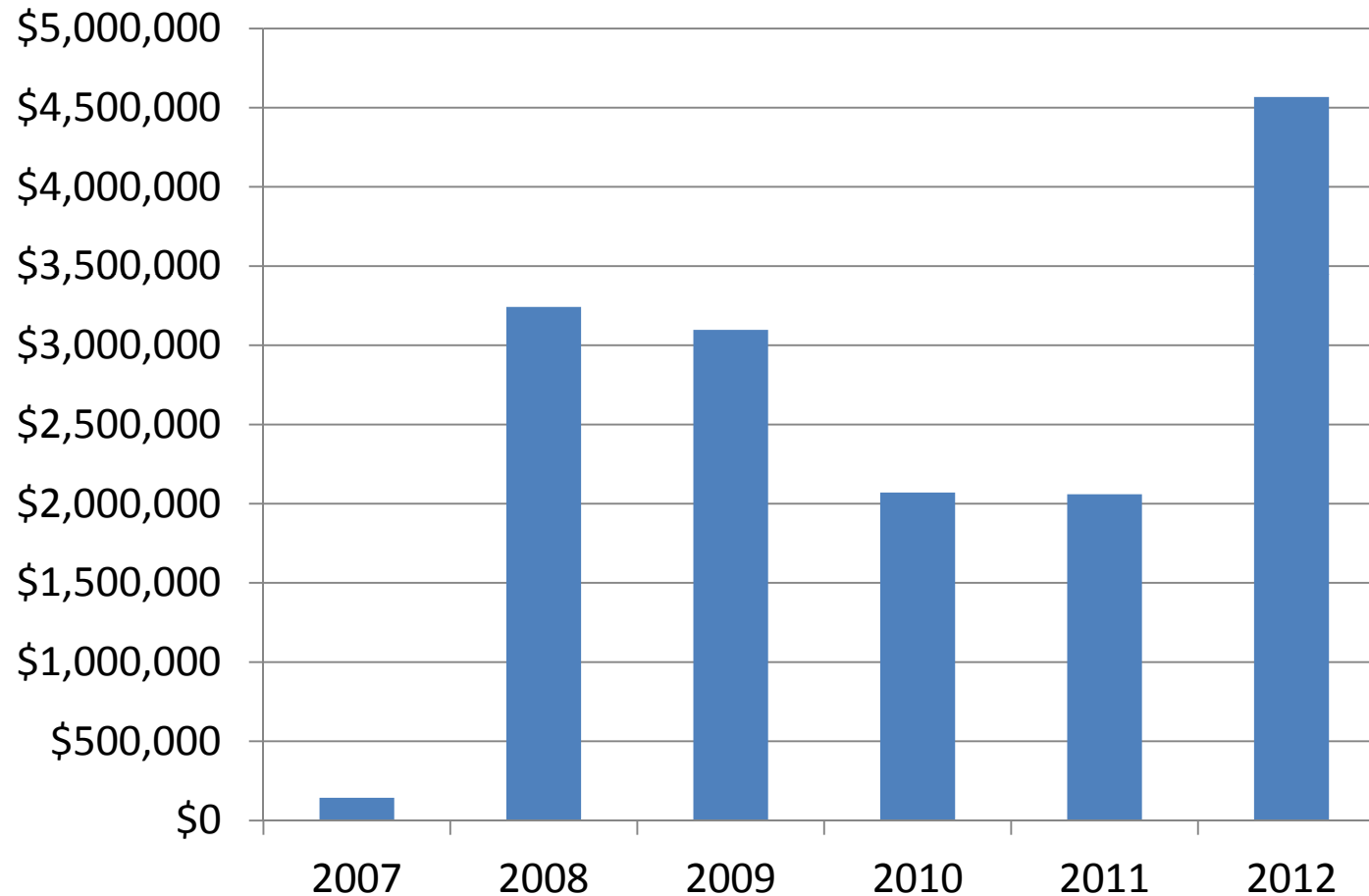


❖ *The next slide shows the results of additional staff reviewing improperly paid claims*



SUR Recoupments

SUR recoupments can go back **6 years** from the date the claim was adjudicated



Examples of SUR Cases

Dentists billing for dentures not provided

Pediatrician billing for tests not done and recipients who were not in the office that day

Personal Care Aides (PCA) billing for care and not providing it, including a case where the PCA was out of the country and turning in timesheets as if he was providing care for a recipient who resides in Las Vegas

Anesthesiologists billing by the minute rather than by the unit, also billing for emergency services that were not justified



Examples of SUR Cases (Continued)

Review of radiopharmaceuticals billed incorrectly

Onsite visits of existing providers

Services billed for date of service after recipient's or provider's date of death

Physicians billing for services actually rendered by the physician's assistant



Impact of Health Care Reform

- Providers face increased scrutiny when applying to become a provider
- Providers are grouped into three categories that signify the potential risk for them to commit fraud:
 - High
 - Moderate
 - Limited
- Each category has additional screening requirements placed on it



Additional Screening Requirements May Include

- License verifications
- Unannounced visits
- Fingerprint-based criminal background checks
- Verification of any provider/supplier-specific requirements established by Medicare
- Database checks
 - Office of the Inspector General
 - State Board of Pharmacy



Additional Entities, Medicaid Fraud Control Unit and Corrective Actions



Reviews Are Done By Many Entities

- Surveillance and Utilization Review (SUR)
- Recovery Audit Contractors (RAC)
- Medicaid Integrity Contractors (MIC)
- Medicaid Fraud Control Unit (MFCU)



Recovery Audit Contractors (RAC)

- A mandate issued by the Affordable Care Act effective January 1, 2012, requires states to contract with one or more RACs to reduce improper Medicaid payments through the efficient detection and collection of overpayments and the detection of underpayments
- States must establish these programs in a manner consistent with state law, and generally in the same manner as the Medicare RAC program
- DHCFP has contracted with Health Management Systems (HMS) and these reviews have started



Medicaid Integrity Contractors (MIC)

- The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP)
 - A major function of the MIP is creation of the contracts with the MICs
- MICs are contracted directly with CMS to conduct data mining activities and provider audits
- Audit results are sent to the affected providers, CMS and to the DHCFP for review and comment
- If an overpayment is discovered, the DHCFP will send a recoupment letter to the provider and will collect the overpayment from the provider



Corrective Actions

DHCFP may take one or more corrective actions including but not limited to:

- Educational contact
- Warning letters
- Special requirements imposed as a condition of participation



Medicaid Fraud Control Unit (MFCU)

If evidence of criminal intent is found, the case is referred for investigation by the MFCU

- Examples:
 - Falsification of provider records
 - Providers billing for a high number of recipients per day
 - Forgery of documents by providers



MFCU

Five ways to report an allegation of Medicaid fraud:

- 1. Email** aginfo@ag.nv.gov
- 2. Mail** Attn: MFCU
Nevada Attorney General's Office
100 N. Carson Street
Carson City, NV 89701
- 3. Call** 775-684-1191
- 4. Fax** 775-684-1192
- 5. Website** <http://ag.state.nv.us>
(File a Complaint tab)



SUR Contact Information

Please contact SUR if you suspect provider fraud. This will ensure that federal and state taxpayer dollars are not being spent on services that are either not rendered or billed incorrectly.

Phone: 775-687-8405

<https://dhcftp.nv.gov/NPIContactUs.asp>

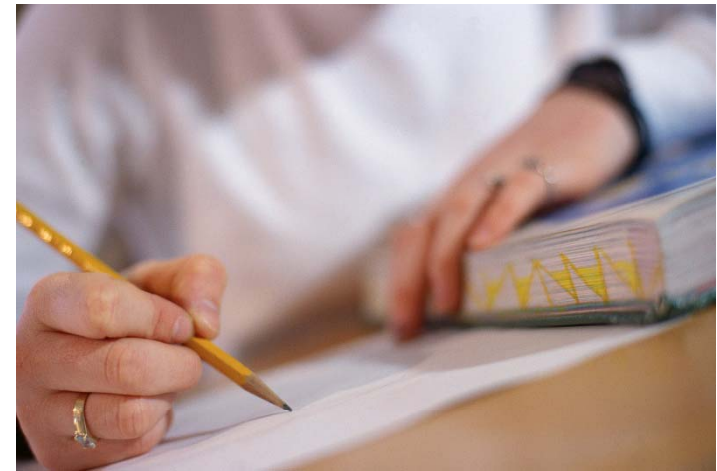
Additionally, by visiting the following website you can find press releases pertaining to Medicaid fraud:

<https://dhcftp.nv.gov/pressreleases.htm>

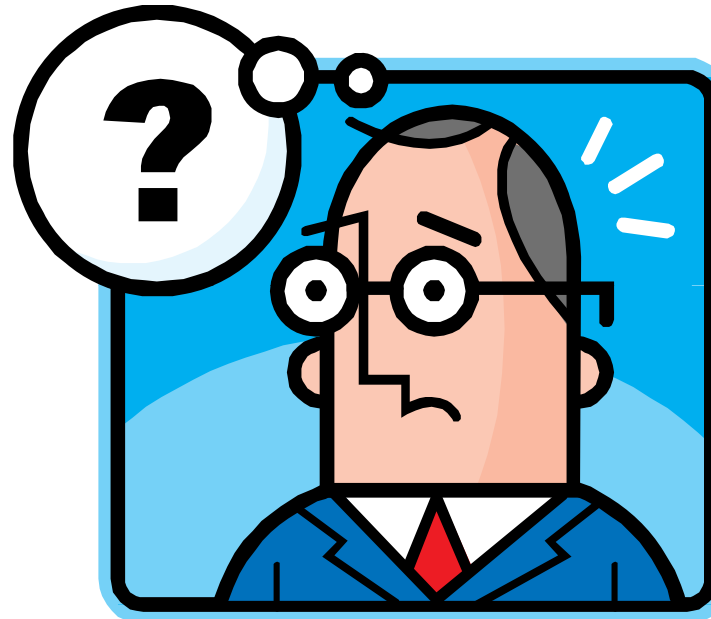


Learning Check

1. True or False – Improper payments can be classified as fraud and/or abuse.
2. How many years can SUR recoupment go back from the date the claim was adjudicated?
3. What are the possible corrective actions DHCFP may take?



Questions?



Thank you for attending this workshop today.
Please remember to download your evaluation
and send it to nevadaprovidertraining@hp.com

or

fax it to: 775-624-5979



Glossary



- **CMS** – Centers for Medicare & Medicaid Services
- **DHCFP** – Division of Health Care Financing and Policy
- **MFCU** – Medicaid Fraud Control Unit
- **MIC** – Medicaid Integrity Contractor
- **MIP** – Medicaid Integrity Program
- **PERM** – Payment Error Rate Measurement
- **RAC** – Recovery Audit Contractors
- **SUR** – Surveillance and Utilization Review