

# Program Integrity and Surveillance Utilization Review (SUR)

Be Aware of  
Medicaid Fraud

Nevada Medicaid and Nevada Check Up  
with HPES



# Today's topics

- Program Integrity
- Surveillance and Utilization Review (SUR)
- Current and past SUR cases
- Impact on providers
- Corrective actions
- Medicaid Fraud Control Unit (MFCU)



# Program integrity

The Department of Health Care Financing and Policy (DHCFP) has three programs to assist in ensuring the fiscal integrity of the Nevada Medicaid program it administers

- Payment Error Rate Measurement (PERM)
  - Financial Compliance Audit
  - SUR Unit
- *See Medicaid Services Manual (MSM) Chapter 3300*



# 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



# Surveillance and Utilization Review (SUR)

- Statewide program to safeguard against unnecessary or inappropriate use of services
- Prevent excess payments in the Nevada Medicaid and Nevada Check Up programs
- 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 and referrals and data mining results
  - Referrals received from various sources
- Complaints received 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

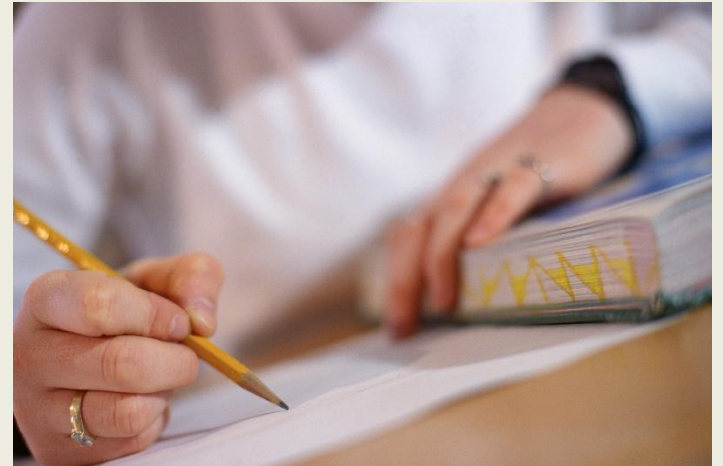
- Investigations include:
  - Policy review
  - Claim payment review
  - Review of outliers



- » 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

# 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?



# Definition of abuse

- 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 CFR 455.2)



# Definition of fraud

- 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)



# Definition of improper payment

- 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
- An improper payment can be an overpayment or an underpayment



# Examples of improper payments

- 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
- Payments not in accordance with applicable pricing or rates
- Data entry errors resulting in incorrect payments
- Payments where the incorrect procedure code was billed (up-coding)



# Examples of improper payments, continued

- 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*



# 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

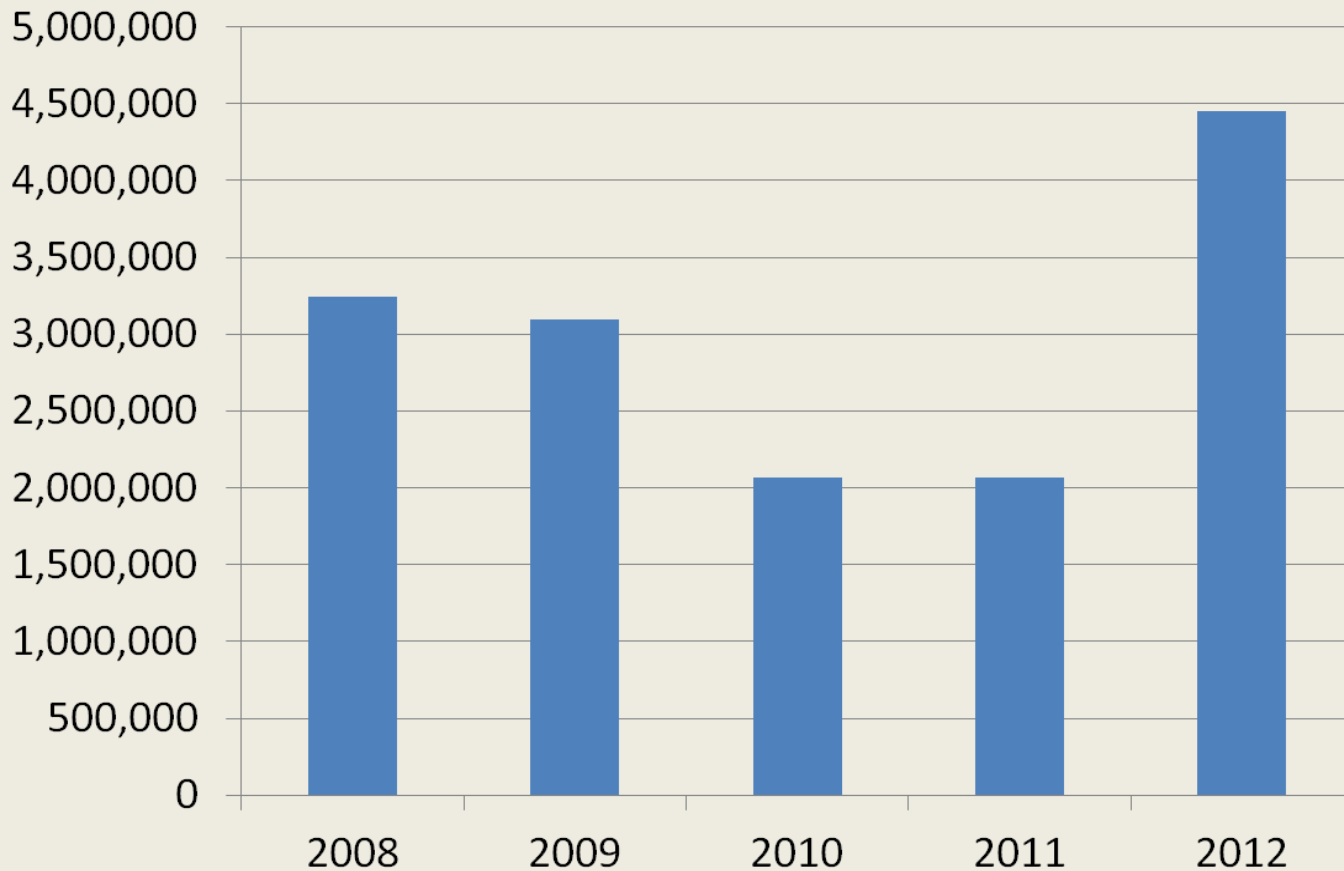
- 2006 there were three employees
- 2009 the unit was increased to ten employees
- 2012 the unit was increased to fourteen employees



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

# SUR recoupment

SUR recoupment can go back **6 years** from the date the claim was adjudicated. The table below shows the amounts recuperated in the past 5 state fiscal years.



# Current and past 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

# Current and past SUR cases, continued

Review of radiopharmaceuticals billed incorrectly

Onsite visits of existing providers

Services billed 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



# Reviews are done by many entities

- Surveillance and Utilization Review (SUR)
- Recovery Audit Contractors (contracted with DHCFP)
- Medicaid Integrity Contractors (contracted with CMS)
- Medicaid Fraud Control Unit (The Office of the Attorney General)



# 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 will be beginning soon





# 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 Division of Health Care Financing and Policy (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 a combination of the possible corrective actions, such as:

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



# Referrals to the 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 timesheets
  - 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](mailto: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://dhcfp.nv.gov/NPIContactUs.asp>

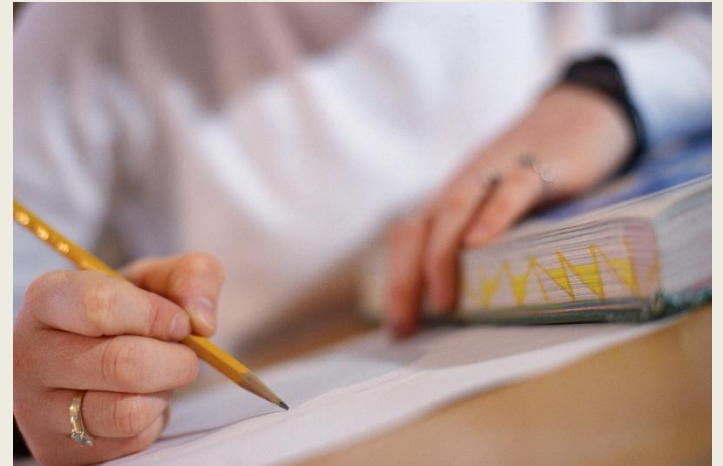
Additionally, by clicking on the following link you can find press releases pertaining to Medicaid fraud:

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

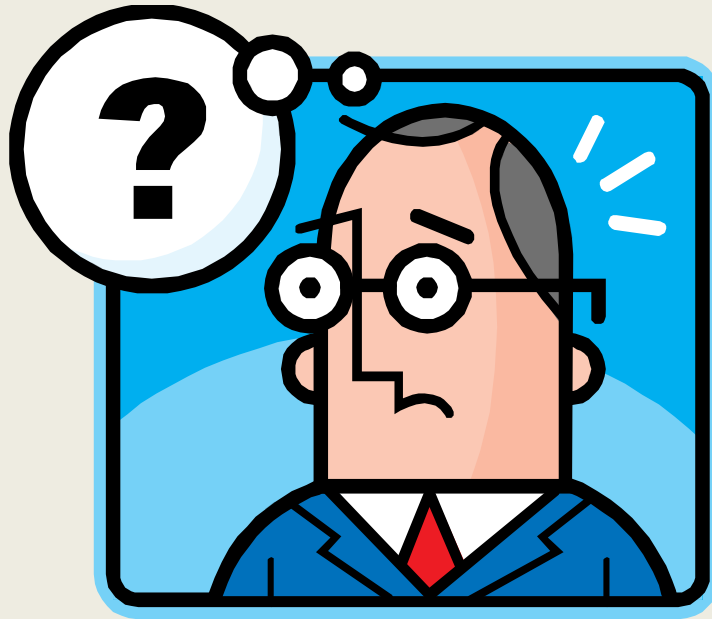


# Learning check

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](mailto: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
- **MPC** – Medicaid Program Contractor
- **MIP** – Medicaid Integrity Program
- **PERM** – Payment Rate Error Measurement
- **RAC** – Recovery Audit Contractors
- **SUR** – Surveillance and Utilization Review