

Prevention of Medicaid Waste, Fraud, and Abuse

Iowa
Association of
Community
Providers



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What we will cover

- Definitions
- Potential Penalties
- Prevention
- Reporting

What is Medicaid Fraud?

- “An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” (42 CFR Part 455.2)

What is Medicaid Abuse?

- “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.” (42 CFR Part 455.2)

Types of Fraud and Abuse

- Billing for services not covered
- Identity Theft
- Billing services not provided
- Kickbacks
- Unbundling
- Upcoding
- Unnecessary Services

Medical Identity Theft

“the appropriation or misuse of a patient’s or [provider’s] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.”

Billing for unnecessary services or items

Under Section 1902(a)(30)(A) of the Social Security Act, States are required to “provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services ...” [6] States may “place appropriate limits on a service based on such criteria as medical necessity ...” [7] Providers are responsible for ensuring that authorized services meet the definition of medical necessity.

Billing for services or items not rendered

To be covered by Medicaid, the billed service or supply must in fact be furnished.

- Billing Medicaid for a covered service or item that is not provided is fraudulent
- Providing different services or supplies is no justification for submitting a bill for a service or supply that was not provided.

Upcoding

Is a term that is not defined in Federal Medicaid regulations, but it is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented

Unbundling

“Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.”

Billing for non-covered services or items

Fraud and abuse may involve services that are provided but are not covered by Medicaid. Providers should only bill for the medically necessary or otherwise authorized services or items actually furnished to beneficiaries, and should ensure that proper documentation is in place.

Kickbacks

Kickbacks can be defined as offering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for referral of patients or the generation of business involving any item or service for which payment may be made under Federal health care programs.[12, 13] Rewarding sources of new business may be acceptable in some industries but not when Federal health care programs and beneficiaries are involved

What is Medicaid Waste?

Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

More about Waste

For purposes of enforcement, there is a difference between unintentional mistakes and fraudulent or abusive behavior. For example, submitting an erroneous claim for payment is different from submitting the same claim with actual knowledge, reckless disregard, or deliberate ignorance of its falsity.[8] An honest mistake should lead to the return of funds to Medicaid. Providers who improperly bill for services risk losing continued eligibility to participate in the Medicaid program and may face criminal and civil monetary penalties.[9]

Improper Medicaid Payments

Improper payments arise as a result of clerical errors, misinterpretation of program rules, or inadequate or poor record keeping. Improper payments include both overpayments and underpayments. While some improper payments are fraud, most are not fraudulent. The vast majority of providers are honest in their billings for Medicaid reimbursement.

Examples of Improper Medicaid Payments

- Services not adequately documented
- Incorrect coding when billing
- Service documentation not meeting Iowa's reimbursement rules and regulations
- Failure to document time in and out, date of services, location, interventions, staff signature
- Errors in calculating units, over or under billing
- Billing for supports and services that are prohibited by rules
- Billing when the individual was hospitalized for 24 hours in a calendar day
- Completing documentation before providing services

Corrections of Improper Documentation

- Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.
- A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
- Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
- If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.
- Improper documentation that cannot be reliably and/or accurately corrected must be paid back to the DHS per 79.2(10).

Penalties

Providers who engage in fraud and abuse are subject to sanctions under a number of Federal and State laws. Sanctions under Federal law, for example, can take the form of administrative, civil, and criminal penalties. These penalties range from monetary fines and damages to prison time and exclusion from the Federal health care programs, including Medicaid.

Penalties

In fiscal year 2014, the government's health care fraud enforcement efforts

- recovered more than \$3 billion
- 734 convicted of health care fraud-related crimes
- Federal prosecutors charged 805 with health care fraud-related crimes

Penalties

The HHS-OIG State Medicaid Fraud Control Units Report for 2014 showed:

- 1,318 criminal convictions
- 874 civil settlements and judgments against providers.
- convictions led to 1,337 provider exclusions
- States recovered a total of \$1.9 billion

Prevention

- Know the laws
 - <http://oig.hhs.gov/compliance/provider-compliance-training/files/HandoutLegalCitations508.pdf>
- Screen for Excluded individuals
- Implement a Compliance Program

Exclusions

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons

Mandatory Exclusions

- Convictions of program-related crimes
- Convictions relating to patient abuse
- Felony convictions relating to health care fraud
- Felony convictions relating to controlled substances

Discretionary Exclusions

- Losing a state license to practice
- Failing to repay student loans
- Conviction of certain misdemeanors
- Failing to provide quality care

Screening for Exclusions

As a Federal health care program, Medicaid will not pay for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.

Screening for Exclusions

CMS advises states to require providers screen their employees and contractors for exclusions by checking the database LEIE and SAM on a monthly basis.

Screening for Exclusions

The List of Excluded Individuals/ Entities (LEIE) database is available at

<http://exclusions.oig.hhs.gov/>

In addition to checking the LEIE, providers should check the Exclusions Extract on the System for Award Management(SAM)website at:

<https://www.sam.gov/>

Iowa Medicaid Provider Agreement

Comply, to the extent required, with 42 U.S.C. § 1396a(a)(68), and the requirements of the False Claims Act by:

- Provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments.
- 1.10.1 Establishing written policies for all employees that include detailed information about the False Claims Act and the other provisions set forth in 42 U.S.C. § 1396a(a)(68). The policies must include detailed information about the Provider's policies and procedures for detecting and preventing waste, fraud, and abuse.
- 1.10.2 Including in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

All Providers Must Develop a Strong Medicaid Compliance Program

- Develop a strong corporate compliance policy with codes of ethical conduct set forth in 42 U.S.C. § 1396a(a)(68).
- Monitor for Medicaid waste, abuse, fraud, and take appropriate corrective actions if problems are identified.
- Monitor to ensure program integrity, compliance with state HCBS rules, and take appropriate corrective actions if problems are identified.
- Provide annual and updated staff training on corporate compliance policy, codes of ethical conduct, and Chapter 79.3(3) documentation requirements.

Compliance Program

HHS-OIG has recommended seven basic elements of a compliance program:

1. Conducting internal monitoring and auditing

- Create an audit plan and re-evaluate it regularly.
- Identify your organization's risk areas.
- Use your networking and compliance resources to get ideas and see what others are doing.
- Don't only focus on the money – also evaluate what caused the problem.
- Create corrective action plans to fix the problem.

Compliance Program

2. Implement written standards and procedures
 - Regularly review and update with department managers and Compliance Committee.
 - Assess whether they are tailored to the intended audience and their job functions.
 - Ensure they are written clearly.
3. Designate a compliance officer or contact(s) to monitor compliance

Compliance Program

4. Conduct training and education on standards and procedures
 - Regularly review and update training programs.
 - Make training completion a job requirement.
 - Test employees' understanding of training topics.
 - Maintain documentation to show which employees received training.
 - Train your Board.
 - Train yourself and your compliance staff.

Compliance Program

5. Respond appropriately to detected violations
6. Developing open lines of communication
 - Have open lines of communication between Compliance Officer (CO) and employees.
 - Maintain an anonymous “hotline” to report issues to you.
 - Enforce a non-retaliation policy for employees who report potential problems.
 - Establish a direct line of communication between CO and the Board.
 - Use newsletters or internal websites to maintain visibility with employees.
 - Regularly meet with the Board and brief them on the compliance program.

Compliance Program

7. Enforcing disciplinary standards through well-publicized guidelines.

- Delegate/empower teams closest to the issues to perform reviews
- Act promptly, and take appropriate corrective action.
- Create a system or process to track resolution of complaints.
- Enforce your policies consistently through appropriate disciplinary action

How do you report suspected Medicaid fraud, waste, or abuse?

- Iowa Medicaid Director, Division of Medical Services, Department of Human Services (DHS), 100 Army Post Road, Des Moines, Iowa 50315, phone number 515.725.1121, fax number 515.725.1010; or
- Iowa Medicaid Fraud Control Unit with the Department of Inspections and Appeals (DIA), Lucas State Office Building, 3rd floor, Des Moines, Iowa 50319, phone number 515.281.6377, or fax number 515.242.6507; or
- Health and Human Services Office of Inspector General, phone number 1.800.hhs.tips, fax number 1.800.223.8164, e-mail hhstips@oig.hhs.gov, mailing address Office of Inspector General, Department of Health and Human Services, ATTN.: hotline, 330 Independence Ave., SW, Washington, DC 20201

How do you report suspected Medicaid fraud, waste, or abuse?

- Each MCO requires reporting as well:
- Amerigroup:
 - Chapter 22 of their provider Manual
- AmeriHealth Caritas
 - Section II, Page 37 of their provider Manual – also on Provider Reference Guide
- United Health Care
 - Fraud, Waste and Abuse: Identification and Reporting Quick Reference Guide located in the Billing and resource guide page of their website

Questions

