The Indiana Family and Social Services Administration

Indiana Health Coverage Programs
Program Integrity (PI)

2016 Annual IHCP Provider Workshops

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Agenda

- Program Integrity
  - Who is Program Integrity?
- Indiana Medicaid PI FADS Audit Process
- Who else audits Indiana Medicaid?
- Voluntary Self Disclosure
- Update from PI Activities
- Questions / Contact Information
Only formal responses to questions asked through the www.in.gov/fssa inquiry process will be considered official and valid by the State. No participant shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee including responses in today’s presentation.
Who or What is Program Integrity?

FSSA Program Integrity (PI) is composed of three collaborative groups:

• Investigations & Coordination
• Prepayment Review
• Surveillance & Utilization Review (SUR) - Audit
Who or What is Program Integrity? (con’t.)

**Investigations & Coordination**

- Respond to complaints from members, providers, other state agencies, etc.
- Conduct preliminary investigations to establish a Credible Allegation of Fraud (CAF)
- Collaborate with Medicaid Fraud Control Unit on provider investigations
- Coordinate with FSSA operating divisions (DDRS, DA, DMHA, DFR) to follow-up on issues of services being paid for and not delivered
- Work with the Managed Care Entities to monitor their Special Investigation Units and referrals of provider fraud allegations
Who or What is Program Integrity?
(con’t.)

- **Prepayment Review**
  - Potential concerns with provider billing practices
  - Provider submission of supporting documentation with claim forms
  - Prepayment Review outcome
  - Must meet 85% accuracy rate in claims submission for three (3) consecutive months within the initial six (6) month review period
  - Based upon review of provider compliance with Prepayment Review:
    - Removal from Prepayment
    - Extension of Prepayment Review
    - Sanction of Provider, up to and including termination from the IHCP, if unable to meet the 85% threshold
Who or What is Program Integrity?
(con’t.)

- **Surveillance & Utilization Review (SUR) - Audit**
  - Retrospective review of provider billing compliance
  - Historically reviewed on Fee-For-Service claims; excluded Managed Care
  - Audit Approach
    - *Provider-specific*
    - *Algorithm-driven*
  - Claim-by-claim vs. extrapolated review
    - Will review all questionable claims if issue or provider claims universe small
    - Employ statistically-valid sampling of claims when universe is very large
    - Results of sample review then extrapolated to entire claims universe
  - Recovery of overpayments – Federal share of all Medicaid recoveries must be repaid to CMS
Indiana Medicaid Program Integrity Audit Process

Why must we audit?

Program Integrity (PI) conducts retrospective reviews of Indiana Medicaid providers to evaluate and document patterns of healthcare provided to recipients, as well as ensure compliance with Indiana Medicaid guidelines and recover any overpayments. This is facilitated through our Fraud & Abuse Detection System (FADS) contractors.

Steps involved in PI retrospective review process:
1. Preliminary review of provider history – determine next steps
2. Request of medical records from IN Medicaid provider
3. Medical record/on-site audit
4. Draft Audit Findings (DAF) letter of preliminary audit results *
5. Administrative Reconsideration Process
6. Final Calculation of Overpayment (FCO) letter
7. Administrative Appeal
8. Repayment of Overpayment
PI Audit Process

1. Preliminary review of provider history
   – Identification and analysis of provider enrollment history and claims data - look for possible patterns of aberrant activity
   – Compare provider with peers of like specialty – outlier?
   – Review any past audit history to identify previous areas of concern
   – Recommendation of proposed action
   – Coordinate and vet recommended action with Indiana Medicaid Fraud Control Unit (MFCU)
   – Initiate recommended action approved by PI
PI Audit Process (con’t)

2. Request of medical records
   – Notice of Audit & Request for Records letter, via certified mail, is sent to the Mail-To address of provider
   – Claims chosen for review can be identified either on a claim-by-claim basis or as a result of a Statistically-Valid Random Sample
   – Audit notification letter details what documentation is requested to facilitate review
   – Providers typically given 30 days to submit the requested documents for review (extensions can be granted when requested in writing by the provider)
   – Requested records may be submitted in hardcopy or electronically through a secure web portal
   – FADS team will follow up with providers if no response is received
   – **Typically not first step in audits resulting from an algorithmic review**
     • Algorithmic audit process can begin with dissemination of the Draft Audit Findings (DAF) letter
PI Audit Process (con’t)

3. Medical record/on-site audit
   – Notice of Audit & Request for Records letter will indicate if audit to be on-site or medical record submission
   – Provider staff may remain with FADS team during review if conducted as an on-site review
   – Main focus of on-site is to gather requested documents as well as open communication with provider to ensure a smooth audit process
   – Copies (not originals) of requested records reviewed by FADS team at their offices
   – Review of IHCP policies, coding regulations, and all other state/federal rules pertinent to the dates of service audited
   – Preliminary audit results discussed with PI during bi-weekly Analytic and Audit Committee meetings
PI Audit Process (con’t)

4. Draft Audit Findings (DAF) letter of preliminary audit results
   – Preliminary audit results, via certified mail, are submitted to provider
   – Claims cited as possibly aberrant are detailed
   – Violation of specific rules and guidelines included as support of audit finding
   – Letter will indicate if the results are claim-specific or extrapolated, with explanation of extrapolation process if applicable
   – Provider is instructed how to submit a Request for Administrative Reconsideration of audit findings if they disagree with the preliminary results
   – Provider is required to indicate through the included Provider Intent Form if they agree with the audit findings and wish to receive the Final Calculation of Overpayment, or if they are requesting Administrative Reconsideration
5. Request for Administrative Reconsideration (RAR)

- On-going dialogue between provider and PI
- Provider is able to submit previously omitted documentation, further explanation of internal processes, and anything else to contest the preliminary audit findings
- **Provider must submit new information, records, or arguments when submitting a RAR** *(PI unable to reconsider preliminary audit results without)*
- Upon receipt of new information, audit results will be reconsidered and any reduction of possible overpayments can be facilitated
- On-going communication takes place between provider and FADS team
- Upon completion of reconsideration, PI will determine if a Response to Request for Administrative Reconsideration letter is appropriate, or if the Final Calculation of Overpayment should be drafted
PI Audit Process (con’t)

6. Final Calculation of Overpayment (FCO)
   – Determination of overpayment to be returned to IHCP, including (if applicable) extrapolated amount
   – Explanation of program non-compliance resulting in overpayment
   – Claim-specific details, including overpayment and any applicable interest
   – Information including detailed steps for provider to submit Administrative Appeal
   – Provider notified of Indiana Code requirement to repay overpayment amount within 300 days of FCO

7. Administrative Appeal
   – Appeal must be submitted within 60 calendar days of FCO receipt
   – Include Statement of Issues along with request for Appeal
   – Must detail specific findings, actions or determinations of the audit the provider is appealing
   – Include rationale for provider’s belief in error of PI determination, as well as statutes & rules supporting providers contentions
   – Appeal is assigned to attorney in FSSA Office of General Counsel and Administrative Law Judge
PI Audit Process (con’t)

8. Repayment of Overpayment

− Provider is required to repay identified overpayments within 300 days of FCO (Indiana Code IC 12-15-13-3.5(e))
− Failure to make repayment within 300 calendar days will result in recoupment against current claim payment
− If provider prevails on appeal, FSSA will return the overpayment amount and any interest the provider may have paid, as well as interest to the provider from the date of the provider’s repayment
− Providers can choose to submit payment by check or have overpayment satisfied through accounts receivables against future payments
− In instances of overpayments due to FSSA system or policy issues, no interest is assessed on identified overpayments.
Who else may audit Indiana Medicaid?

Reviews can be initiated by other external entities in conjunction with IN Program Integrity, including, but not limited to:

- **CMS**
  - *Payment Error Rate Measurement (PERM) audit*
    - 3-year cycle
    - Establish state-wide error rate from sample audit
    - **A+ Gov’t. Solutions and The Lewin Group** (vendors)
    - Next audit cycle [FFY 2017] begins August 2016
  - *Medicaid Integrity Contractor (MIC)*
    - Audit contractor directed to assist State PI efforts – CMS approves audits
    - Indiana MIC vendor = **Health Integrity (HI)**
    - Works collaboratively with IN PI
  - *Unified Program Integrity Contractor (UPIC)*
    - Replacing the MIC; serving essentially the same function
    - Indiana UPIC vendor = NCI AdvanceMed
Who else may audit Indiana Medicaid?
(con’t.)

- **Recovery Audit Contractor (RAC)**
  - Indiana contractor – HMS
  - Focused on credit-balance audits & reviews of LTC providers

- **Department of Health & Human Services – Office of Inspector General**
  - Issue-specific reviews (ie. code billed; drug dispensed; service ordered)
  - Contact State PI to pull claims data to review
  - Findings of issue directed to State Medicaid program to pursue recovery and develop a Corrective Action Plan (CAP), if warranted
  - Recent examples:
    - “Questionable Billing for Medicaid Pediatric Dental Services in Indiana”
    - “Indiana Made Incorrect Medicaid Payments to Providers for Full Vials of Herceptin”
    - “Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable”
  - State PI works to validate audit results, then utilize standard State process to recover overpayments
Who else may audit Indiana Medicaid? (con’t.)

• **Indiana Medicaid Fraud Control Unit (MFCU)**

  *Fraud* is an intentional deception or misrepresentation, made by the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. The following list contains examples of fraud:

  • Altering a member’s medical records to generate fraudulent payments
  • Billing for group visits, such as a provider billing for several members of the same family in one visit, although only one family member was seen or provided medically necessary services
  • Billing for services or supplies that were not rendered or provided
  • Misrepresenting services provided (for example, billing a covered procedure code and providing a non-covered service)
  • Soliciting, offering, or receiving a kickback, bribe, or rebate
  • Submitting claim forms that have been altered or manipulated to obtain higher reimbursement
Provider Voluntary Self-Disclosure

Mandatory reporting 42 U.S.C. § 1320a-7k(d)

• Provider Self-Disclosure packet located on the State PI website
  • [http://provider.indianamedicaid.com/about-indiana-medicaid/program-integrity.aspx](http://provider.indianamedicaid.com/about-indiana-medicaid/program-integrity.aspx)
PROGRAM INTEGRITY

MISSION STATEMENT

The mission of the Office of Medicaid Policy and Planning (OMPP) Program Integrity Unit is to guard against fraud, abuse, and waste of Medicaid program benefits and resources.

CONTACT INFORMATION

Member and Provider Concerns line: 1-800-457-4515
Program Integrity email: programintegrity@fssa.in.gov

FREQUENTLY ASKED QUESTIONS

Q. What is provider fraud?
   A. Misrepresentation with the intent to illegally obtain services, payments, or other gains.

   Examples include, but are not limited to:
   - Billing for services not rendered
   - Billing for services not provided
   - Billing for more costly services than rendered (upcoding)
   - Billing for services not provided to the general public
   - Billing for services provided by unlicensed or unlicensed personnel
   - Receiving kickbacks from medical providers for referrals or use of a product

Q. What is provider abuse?
   A. Any action that is inconsistent with generally accepted practices (both clinically and from a business standpoint) which results in an incorrect payment for services rendered.

   Examples include, but are not limited to:
   - Rendering or ordering excessive services, especially diagnostic tests
   - Providing services inconsistent with the diagnosis and treatment of the recipient
   - Rendering or ordering medically unnecessary services
   - Poor or unsatisfactory quality of care provided to a recipient
   - Billing recipient for remaining balance after Medicaid payment

Q. What are the potential consequences to the provider for fraudulent or abusive activities?
   A. Potential consequences to the provider depend on the intent demonstrated and the severity of the activity.

   Examples include, but are not limited to:
   - Criminal investigation and/or prosecution
   - Civil monetary penalties
   - Exclusion by the Office of the Inspector General from Medicare and/or Medicaid, permanently or for a period of time
   - Referral to the Indiana Professional Licensing Agency
   - Pre-payment review
   - Payment suspension
   - Recoupment of Medicaid overpayment
   - Other administrative remandacy
“(d) Reporting and Returning of Overpayments – (1) in general, - If a person has received an overpayment, the person shall -

A.) Report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

B.) Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.”
Report and Return to Correct Address

Standardized tool for reporting overpayments

Notify with reason for overpayment

In Indiana, overpayments should be returned, reported and explained to the PI Unit at the following address:

IHCP Program Integrity Department
ATTN: SUR Audit Overpayment
P. O. Box 636297
Cincinnati, OH 45263-6297
“(2) Deadline for reporting and returning overpayments. - An overpayment must be reported and returned under paragraph (1) by the later of -

A.) The date which is 60 days after the date on which the overpayment was identified; or

B.) The date any corresponding cost report is due, if applicable.”
Additional Benefit of Provider Voluntary Self-disclosure

405 IAC 1-1-5 Overpayments made to providers; recovery
Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 4-6-10; IC 4-21.5-3; IC 12-15-1; IC 12-15-6-5; IC 12-15-23-2
(g) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the percentage set out in IC 12-15-13-3(e)(1) [IC 12-15-13-3 was repealed by P.L.229-2011, SECTION 270, effective July 1, 2011]. Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. Under IC 12-15-21-3(6), the interest shall:
(1) accrue from the date of the overpayment to the provider; and
(2) apply to the net outstanding overpayment during the periods in which such overpayment exists.

In instances of provider self-disclosure, interest is not assessed on the disclosed overpayment amount.
Federal Exclusions

• Excluded Individuals
  • http://www.oig.hhs.gov/fraud/exclusions.asp
  • https://www.sam.gov/portal/public/SAM/
  • The Online Searchable Databases enable users to enter the name of an individual or entity and determine whether they are currently excluded. If a name match is made, the database can verify the match using a Social Security Number or Employer Identification Number.
  • Any claims involving excluded individuals or business will be recouped in full as overpayments
  • Also refer to IHCP Provider Bulletin BT200715 (Federal Health Care Exclusions Program)
False Claims and Whistleblower Regulations

- Indiana enacted State False Claim and Whistleblower statute: Indiana Code 5-11-5.7
- Federal False Claims Act: 31 USC § 3729-3733
- Report Medicaid Fraud to Attorney General: http://www.in.gov/attorneygeneral/2453.htm
- False Claims and Whistleblower education: http://www.in.gov/attorneygeneral/2807.htm
Avoiding Billing Errors

• FSSA PI works with IN Fraud and Abuse Detection System (FADS) contractors to identify potential billing problems
• Select billing issues related to claims processing glitches – no interest assessed on overpayments
• Recent analytical reviews focused on the following areas:
  – Unbundled Radiologic Guidance
  – One-day Inpatient Stays
  – “Trips to Nowhere”
  – Unbundled Dialysis Supplies
  – Upcoded/Unbundled Dental Restorations
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THANK YOU!