

RAC SUMMIT 2011  
TOP ISSUES IN MEDICAID  
AUDIT

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# WHAT YOU NEED TO KNOW FROM THIS PRESENTATION

- Significant changes in government approaches to compliance and audits
- Requires changes in your business practices and compliance program
- Requires you to know about entities performing the audits and their focus.

# THE COMPLEXITY OF THE MEDICAID AUDIT WORLD

- Existing state audit agencies and contractors – NY OMIG, NJ Controller, Pa. DPW, UMass
- HHS-OIG
- Law enforcement agencies with audit authority (Medicaid Fraud Control Units, US Attorney Offices)
- Medicaid Integrity Contractors (2008)
- Medicaid RACs (2011-12)



# THE COMPLEXITY OF THE MEDICAID AUDIT WORLD

- How are audit entities accountable?
  - MIC (Medicaid Integrity Contractors)- reimbursed on a fee for service basis by CMS- keep the customer (CMS) satisfied
  - RAC –reimbursed on a % of recoveries basis by state Medicaid-maximize recoveries consistent with state rules
  - -Medicaid Fraud Control Units-responsive to the agenda of the elected Attorney General who supervises them

# THE COMPLEXITY OF THE MEDICAID AUDIT WORLD

- How are audit entities accountable?
  - State program integrity agencies within Medicaid-deal with elected state officials, often supervised by State Medicaid Director-but must also comply with CMS regulatory requirements of Medicaid Integrity Program
  - CMS Medicaid Program Integrity-subject to 2006 Deficit Reduction Act requirements and Congressional oversight (including GAO)
  - Department of Justice-HEAT initiative, whistleblower enforcement



# THE COMPLEXITY OF THE MEDICAID AUDIT WORLD

- How are audit entities accountable
  - HHS/OIG - oversight of program agencies (CMS and states)
    - Semiannual reports
    - Identified overpayments (CMS to collect)
    - Congressional hearings and testimony
    - Program improvement opportunities

# THE COMPLEXITY OF THE MEDICAID AUDIT WORLD

- New players in “audit”-media and public
- South Carolina-put provider data on line
- Wall Street Journal November 5, 2011
  - “In Medicare’s data trove, clues to curing cost crisis”
  - WSJ sued to obtain access to provider specific records-case pending in Fl.
  - New York Times November 6,2011
  - Causes of 1200 deaths in facilities for persons with disabilities, run by or paid for by state



# MEDICAID AUDIT-NEW PLAYERS

- Mandatory reporting and refund of overpayments
  - Mandatory Compliance programs in business partners
  - HOSPITALS/PHYSICIANS (Stark)
  - PHARMA/DEVICE COMPANIES WITH PHYSICIANS (Sunshine Act)
  - BILLING COMPANIES AND PROVIDERS
  - MANAGED CARE AND PROVIDERS
  - IRS 990 review for non-profits



# A STORY OF A 2011 MEDICAID CASE

- Dr. Howard Goldstein, Missouri psychiatrist

# DR. GOLDSTEIN'S DEFENSE

- Dr. Howard Goldstein was a "workhorse" who saw dozens of patients in a room at a time but "does not write well," defense lawyer Albert Watkins explained.
- Watkins said that caused Goldstein's employer, SSM St. Charles Clinic Medical Group Inc., to question his billings and **led Dr. Goldstein to use computerized records whose repetitive entries** became the subject of a federal probe.



# SSM St. Charles Medical Group

- 2007-Audited Dr. Goldstein -records “scant and illegible”
- Considered firing, but sent him to coding education classes
- 2009-routine peer review identifies continued record issues-reported to compliance officer, who reported to DOJ
- SSM to pay \$865,812

# SSM St. Charles Medical Group

- Repaid \$870,000 to federal and state governments
- No CIA
- No monitor
- Commendation by US Attorney's Office



# Lessons from Dr. Goldstein case

- What routine monitoring do you undertake?
- What actions do you take when physicians records do not support billing?
- What records do you make of findings?
- What records do you make of corrective actions?
- What do you do to monitor current actions of non-compliant physicians?
- You are responsible for employee bills

# A STORY OF A 2011 MEDICAID CASE

- Maxim Health, a Medicaid home health agency doing business in multiple states
- No or minimal records supported billings for services
- Evidence of obstruction (destruction of records, discouraging testimony)



# RICHARD WEST-PATIENT - MAXIM WHISTLEBLOWER

- "I'm on oxygen, I wasn't getting the nursing care I needed and services were being cut back because of me being over the so-called spending limit. There were times I thought I would die."
- After checking his own medical records, he discovered the company providing him with nursing care appeared to have overbilled Medicaid for hundreds of hours for people who were never there.

# MAXIM HOME HEALTH-2011- THE NEW MODEL HEALTH CASE

- Maxim Healthcare Services, company with 360 offices nationwide offering home health care services, agrees to pay about \$150 million to settle civil and criminal charges -false billings to Medicaid and the Department of Veterans Affairs (no Medicare)
- nine current and former Maxim employees have pleaded guilty since 2009 to felony charges



# MAXIM CONSPIRACY TO DEFRAUD-criminal information

- “Maxim emphasized sales goals at the expense of clinical and compliance responsibilities”
- During the relevant time period, Maxim did not have in place “appropriate training and compliance programs to prevent and identify fraudulent conduct.”
- “Relevant time period” before ACA.

# MAXIM PROSECUTION

- Criminal Information
  - False documents re training
  - False documents re evaluations by supervisors
  - Billing through licensed offices other than the unlicensed office where care was actually supervised
  - Documents certified that mandated training had been received when it had not been
  - CONDITIONS OF PARTICIPATION VIOLATIONS AS BASIS FOR CRIMINAL PROSECUTION



# MAXIM CIVIL FALSE CLAIMS RELEASE

- “submitting or causing to be submitted false claims to state Medicaid programs and the VA, for services not reimbursable by state Medicaid programs or the VA because Maxim lacked adequate documentation to support the services purported to have been performed”

# MAXIM CIVIL FALSE CLAIMS RELEASE

- “for the following offices, during the following periods, submitting or causing to be submitted false or fraudulent claims to state Medicaid programs for services not reimbursable by state Medicaid programs because the offices were unlicensed:”



# MAXIM DEFERRED PROSECUTION AGREEMENT

- "The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program." DOJ press release 9/12/2011

# MAXIM DEFERRED PROSECUTION AGREEMENT

- “reforms and remedial actions the company has taken – beginning in May 2009-establishing and filling of positions of chief executive officer, chief compliance officer, chief operations officer/chief clinical officer, chief quality officer/chief medical officer, chief culture officer, chief financial and strategy officer, and vice president of human resources; hiring a new general counsel”



# MAXIM RESOLUTION

- Eight former Maxim employees, including three senior managers, have pleaded guilty to felony charges in federal court in Trenton, N.J.
- DEFERRED PROSECUTION AGREEMENT- INCLUDING ADMISSION OF CHARGES IN INFORMATION
- CORPORATE INTEGRITY AGREEMENT
- \$150 million in FCA damages and criminal penalties

# MAXIM

- No Medicare-but federal prosecution
- Cooperation against senior executives
- Medicaid home health-traditionally considered difficult investigative subject area
- Patient as whistleblower
- This is a 2004 case-if filed now, states would be required by CMS to suspend payment during "an investigation of credible allegation of fraud."



# OIG 2012 WORKPLAN

- THREE MAJOR AREAS
- Pharmacy
- Home, Community, and Personal Care Services
- Other

# OIG 2012 WORKPLAN

- Claims With Inactive or Invalid Physician Identifier Numbers
- Beneficiaries With Multiple Medicaid Identification Numbers
- Federally Excluded Providers and Suppliers
- Overpayments: Medicaid Credit Balances
- States' Efforts To Improve Third-Party Liability Payment Collections in Medicaid



# OIG 2012 WORKPLAN-MCOs

- Completeness and Accuracy of Managed Care Encounter Data
- Managed Care Entities' Marketing Practices
- Excluded Individuals Employed by in Managed Care Networks
- Managed Care Organizations' Use of Prepayment Review To Detect and Deter Fraud and Abuse .

# HEALTH FRAUD AND ABUSE ENFORCEMENT-A GROWTH BUSINESS

- GAO and CONGRESS to CMS:
  - You must measure and report improper payments
  - you must use contractors to recover improper payments
  - you must measure and report on ROI (return on investment) from your contractors' recovery efforts



# NEW CMS REVIEWS

- "Predictive modeling technology (is being applied) to Medicare fee-for-service claims nationwide July 1, 2011. All claims across the country are now being screened before they are paid. The ones with the highest risk scores will receive immediate attention and additional review by our analysts through our new rapid response strategy." Dr. Peter Budetti, Director, CMS Center for Program Integrity

# PREDICTIVE MODELING

- The Small Business Jobs Act of 2010, signed Sept. 27, 2010 requires the Center for Medicare & Medicaid Services (CMS) to “adopt predictive modeling and other analytics technologies to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.”
- two year predictive modeling contest for hospital admissions. WSJ 3/16/11
- GAO Report GAO-11-409T 3/9/2011-5 steps to reduce M/M fraud, waste, abuse, including data mining, better predictive modeling, followup to RAC findings on providers



# OLD-FASHIONED DATA MINING

- FOCUS ON CLAIMS
  - Edits
    - Pay and report
    - Don't pay
  - Prior authorization
  - Diagnosis and service
  - Bundling/unbundling
  - Inpatient/outpatients same day

# OLD-FASHIONED DATA MINING: COMPLIANCE RESPONSE

- Why are your claims being denied?
- Revenue and compliance issues
- Edit codes
  - Patient was in hospital at time outpatient service allegedly rendered
  - Patient was dead at time service rendered
  - Roster billing
  - Other insurance



# COMPLIANCE RESPONSE TO CURRENT PHARMACY DATA MINING

- What record do your physicians make of change authorizations in prescriptions?
- What records do you require on prescription of controlled substances?
- What controls do you have on controlled substances prescription forms?
- How does your practice address patients with need for pain meds?

# THE 6402 (a) Compliance Challenge

- "AVOIDS "
- "OBLIGATION"
- "IDENTIFY"
- "TEMPORARY"
- "OVERPAYMENT"



# THE LEGAL FRAMEWORK FOR DATA MINING AND REPORTING

- DEFICIT REDUCTION ACT OF 2005 (DRA)
- FRAUD ENFORCEMENT AND RECOVERY ACT OF 2009(FERA)
- THE AFFORDABLE CARE ACT OF 2010 (ACA)
- IMPROPER PAYMENTS ACT OF 2002/IMPROPER PAYMENTS ELIMINATION AND RECOVERY ACT OF 2010(IPERA) (P.L. 111-204)

# DEFICIT REDUCTION ACT OF 2005?

- ENHANCED DATA ON THIRD PARTY LIABILITY
- PERMANENT DATA-SUPPORTED RACS (first recapture audits)
- MEDICAID MICS w/specific dm contractors
- MEDICAID INTEGRITY GROUP AT CMS
- CREATION OF MEDICAID INTEGRITY INSTITUTE TO TRAIN STATE MI STAFF
- REGULAR REVIEWS OF STATE MEDICAID PROGRAM INTEGRITY UNITS
- CREATION OF NY OMIG



# *ACA SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.*

- *“(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.*

# *SEC. 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.*

- *“(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.*



# EXAMPLES OF OVERPAYMENTS

- Services provided by excluded persons
- Services ordered by excluded persons
- Services “provided” to deceased persons
- Mispriced drugs
- Credit balances
- Claims billed and paid twice
- No record of treatment of patient
- Copied progress note
- Default entry of diagnosis
- NOTE: No need for bad intent
- NOTE: Stark violations governed by different disclosure policy

# PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT

- NO CMS REGULATION OR GUIDANCE; NO PLANS FOR REGULATION OR GUIDANCE
- PA 2010 self-audit protocol: Medical Assistance Bulletin 99-02-13, <http://www.dpw.state.pa.us>
- NJ Self-Disclosure Process [www.nj.state.us/njomig](http://www.nj.state.us/njomig)
- NY OMIG's Disclosure Protocol, available on the OMIG website, [www.OMIG@.ny.gov](http://www.OMIG.ny.gov)
- Mass., Ct. Do not yet have disclosure protocols
- COMPARE WITH federal OIG self-disclosure protocol <http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>.
- COMPARE WITH "unsolicited/voluntary refunds" to Medicare contractors (last checked July 2, 2010)
- See, e.g., <http://www.wpsmedicare.com>



# PROVIDER MUST REPORT AND RETURN THE OVERPAYMENT AND STATE THE REASON, IN WRITING FOR THE PAYMENT-WHAT ABOUT MANAGED CARE?

- "This protocol is equally applicable to managed care providers. Inappropriate payments made by managed care organizations (MCOs) to providers within their networks inflate the costs of providing care to MA recipients, and DPW retains its right and responsibility to identify and recover payments or take any other action available under law. While DPW will return to the applicable MCO any payments identified through this protocol, providers must make the self disclosure directly to DPW." (Pa.)

# PA. Medical Assistance Provider Self-Audit Protocol

- Option 1 - 100 Percent Claim Review - A provider may identify actual inappropriate payments by performing a 100 percent review of claims
- Option 2 - Provider-Developed Audit Work Plan for BPI Approval
- Option 3 - DPW Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SVRS)



# WHO IS MOST LIKELY TO USE THE FERA FCA PROVISIONS TO ENFORCE THE 6402 ACA DUTY?

- WHISTLEBLOWERS AND THEIR COUNSEL
  - Data analysis for whistleblower case evaluation, supporting whistleblower allegation
    - Using your data and benchmarks
    - Matching exclusion lists against employee/contractor lists
    - Publicly available data on outliers
    - Discovery and access to govt. data and documents
    - Publicly available data on provider behavior
    - Best practices research

# MANDATORY COMPLIANCE PLANS

- ACA requires CMS to issue regulations governing mandatory compliance plans for nursing facilities by March 24, 2012; required facility compliance by 3/24/2013
- Look for draft regs in fall of 2011
- “obligation”
- “identify”
- Auditing and risk assessment



# MEDICAID: Credible allegation of fraud

- **§ 455.2 Definitions.** Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:
  - (1) Fraud hotline complaints.
  - (2) **Claims data mining.**
  - (3) Patterns identified through **provider audits**, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for

# §455.23 Suspension of payments in cases of fraud (Medicaid)

- (a) Basis for suspension.
- (1) The State Medicaid agency **must suspend all Medicaid payments** to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.
- (2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.
- (3) A provider may request, and must be granted, administrative review where State law so requires.
- January 24, 2011 Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers Final Regulation, Proposed



# THE CHANGING LANDSCAPE OF “IMPROPER PAYMENTS”: FEDERAL AGENCY, CONTRACTOR AND GRANTEE ACCOUNTABILITY

- **Improper Payments Elimination and Recovery Act of 2010 (IPERA) (P.L. 111-204)**

# WHAT IS AN IMPROPER PAYMENT?

- "An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. An improper payment includes any payment that was made to an ineligible recipient or for an ineligible service, duplicate payments, payments for services not received, and payments that are for the incorrect amount. "



# "RECAPTURE AUDITS"

- "One approach that has worked effectively is using professional and specialized auditors on a contingency basis, with their compensation tied to the identification of misspent funds. "
- "I hereby direct executive departments and agencies to expand their use of Payment Recapture Audits, to the extent permitted by law and where **cost-effective**."
- Presidential Memorandum Regarding Finding and Recapturing Improper Payments March 10,2010

# SO HOW ARE THEY DOING

- HHS GOALS FOR MEDICAID
- ERROR RATE 2010:9.4%
- ERROR RATE 2013: 6.4%
- *FY 2010 HHS Agency Financial Report*



# OMIG FREE STUFF!

[www.omig.ny.gov](http://www.omig.ny.gov)

- Model compliance programs-hospitals (coming soon) and Compliance Alerts
- Over 3000 provider audit reports, detailing findings in specific industry
- Annual work plans for 2009, 2010, and 2011
- New York excluded provider list
- Self-Disclosure protocol
- Corporate Integrity Agreements
- Listserv
- Link to sites for all 18 states which currently publish their state exclusion lists