Washington State Health Care Authority

Medicaid Program Integrity

Documented Educational Intervention

December 2023

Disclaimer

The information provided in this educational intervention is not intended to be a comprehensive detailed account of all legal requirements relevant to compliance with Medicaid program integrity laws and regulations.

Health Care Authority (HCA) encourages all providers and entities to consult with their legal counsel, Board of Directors, or other business advisors about compliance with Medicaid laws and regulations.

Training Areas

This training document will address the following areas:

- Pharmacy
- Hospital audit
- Dental audit
- COVID-related issues
- General program integrity overview and activities
- Summary of audit results for 2022 and description of common issues
- Opportunities for improvement

HCA Program Integrity

Program integrity is federally mandated to protect the integrity of Apple Health (Medicaid) programs. It prevents, identifies, and investigates potential fraud, waste, and abuse within Apple Health. Credible allegations of fraud are referred to the Medicaid Fraud Control Division or other law enforcement. Paid claims and managed care organization (MCO) encounters are reviewed to ensure Apple Health funds are used appropriately.

Law Requiring Annual Training

RCW 74.09.195 Audits of health care providers by the authority – Requirements – Procedure.

- Law became effective in 2017
- Required annual training for providers
- Required topics:
    - Summary of audit results
    - Description of common issues
    - Problems and mistakes identified through audits and reviews
    - Opportunities for improvement

RCW 74.09.195 – Other Provisions

Other requirements or limitations includes:

- 30 days' notice to providers for on-site audits
- Good faith effort to establish mutually agreed date for on-site audit
- Allow providers to submit requested records electronically
- Make reasonable efforts to avoid reviewing claims previously audited
- Established criteria for use of extrapolation of audit findings
- Established notification requirements on audit findings
- Established collection requirements for overpayments
- Establishment of process for resubmission of claims or adjustments

RCW 74.09.195 Extrapolated Audits

A finding of overpayment to a provider in a program operated or administered by the authority may not be based on extrapolation unless:

- There is a determination of sustained high level of payment error involving the provider; or
- When documented educational intervention has failed to correct the level of payment error.

Any finding that is based upon extrapolation, and the related sampling, must be established to be statistically fair and reasonable to be valid.

The sampling methodology used must be validated by a statistician or person with equivalent experience as having a confidence level of 95 percent or greater.

Agency Rules – Extrapolation

Agency Program Integrity Rules – Chapter 182-502A Washington Administrative Code (WAC)

WAC 182-502A-0601 Extrapolation.

(1) To determine an improper payment from a sample, the Medicaid agency may extrapolate to the universe from which the sample was drawn:
(a) If the audit identifies a sustained high level of payment error involving the provider; or
(b) When the agency has documented educational intervention to the provider and the education has failed to correct the provider's level of payment error.
(2) If during the course of the audit, an entity adjusts or rebills a claim or encounter that is part of the audit sample or universe, the original claim or encounter amount remains in the audit sample or universe.
(3) When the agency uses the results of an audit sample to extrapolate the amount to be recovered, the agency provides the entity with the following information:
(a) The sample size.
(b) The method used to select the sample.
(c) The universe from which the sample was drawn.
(d) Any formulas or calculations used to determine the amount of the improper payment.

Documented Educational Intervention

WAC 182-502A-0201 Definitions for program integrity rules

Educational intervention means agency-provided education to an entity prior to or following an agency-initiated program integrity activity that has identified an adverse determination. Educational intervention includes, but is not limited to, any notice of adverse determinations issued by the agency or any agency training that has failed to correct the level of payment error.

Sustained high level of payment error means the net payment error rate is equal to or exceeds five percent for the audit period.

Note: Audit findings are an example of an educational intervention, and this annual training is also a documented educational intervention for purposes of extrapolation.

Program Integrity Activities

Program integrity activities include:

- Pre- and post-payment program integrity audits
- Clinical reviews, hospital payments, pharmacy payments, dental payments, and COVID-19
- Utilization reviews
- Data analytics/algorithms
- Investigations of allegations of fraud
- Education and outreach

Each of these program integrity activities have a unique focus, schedule, and methods as described in the following sections.

Clinical Reviews

- Primary focus is inpatient hospital
- Based on screening criteria, referrals or complaints, and areas of vulnerabilities published by CMS/HHS/OIG or outliers through data mining
- Methods:
    - Record review, issuance of preliminary notice and findings, with informal dispute process
    - Potential adjustment to findings, if warranted, issuance of final notice, report, and findings with formal appeal process
    - Improper payment resolution

Utilization Reviews

- Focus is any provider, service or MCO
- Based on referrals or complaints, or outliers through data mining
- Methods:
    - Record review, issuance of draft report and findings, with informal dispute process
    - Potential adjustment to findings, if warranted, issuance of final notice, report, and findings with formal appeal process
    - Improper payment resolution

Data Analytics and Algorithms

- Focus is any provider, service, or MCO
- Based on referrals or complaints, outliers through data mining, or identified system edit/policy vulnerabilities
- Results in issuance of an overpayment notice, informal dispute, and formal appeal process
- Overpayment resolution

For each provider category we may look for different types of inappropriate billing as follows:

Hospital Audits

Some of the things we look for:

- Provider preventable conditions and health care acquired conditions
- Inpatient hospital readmissions
- Billing ER visits that occur within 1 day of inpatient admission. DRG payment methodology requires all workup related to the DRG be included in the DRG payment.
- Alien Emergency Medical (AEM) clients with claims not covered by AEM
- Medical documentation lacking support for the level of the service/supply ordered and proper signatures. Frequent areas noted this past year:
    - Pharmacy and I.V. therapy (i.e., physician order, time, and initials of nurse administering medication, medication amount)
    - Medical/surgical supplies: usage not documented; length of time item used; billing beyond time used
    - Overbilling of time for surgery, recovery room, anesthesia, and observation room: medical documentation does not support time billed
    - Emergency room level: Level of care billed not supported by medical documentation or hospital criteria for emergency room level
    - Medical chart missing or incomplete documentation
- Diagnosis codes not appropriate for the documented treatment, etc.
- Upcoding, unbundled codes and services, etc.
- Billing the MCO for carved out services and being paid by fee-for-service (FFS) and the MCO.
- Noncovered services to include:
    - Personal care items (e.g., slippers, shampoo)
    - Take-home drugs
    - Billing for radiology contrast material when patient does not meet Department of Social and Health Services (DSHS) medical guidelines for separate billing of contrast material
    - Purchase of crutches
    - Callback charge
    - Point of care testing (bedside nursing services)

Pharmacy Audits

Some of the things we look for:

- Missing or insufficient documentation (expedited prior authorization (EPA) criteria not met)
    - No order/prescription or insufficient order/prescription
    - No delivery document or insufficient delivery document
- Non-covered services
- Billed prior to date of delivery
- Billed quantity/units of service error

- Duplicate payments
- Incorrect code assignment
- Incorrect item dispensed
- Other specialty provider: 340B providers billing higher than Actual Acquisition Cost (AAC) for 340B drugs.

Dental Audits

Some of the things we look for:

- Services normally performed in one visit that are split up. Must document clinical need for not being performed in the same visit, even when split between different days.
- Unbundling services
- Upcoding simple to surgical extractions
- Billing behavior management as an add on code when medical necessity or the behavior management technique employed was not documented in the chart
- Billing palliative care without documenting the treatment or need
- Billing a comprehensive exam without documentation of all the required elements
- Billing D0140 (limited oral eval, problem focused) for a non-emergency, scheduled appointment.
- Exceeding service limits (e.g. prophy, fluoride)
- Palliative treatment that does not have a tooth designation but requires tooth designation. Or palliative treatment billed on the same day as definitive treatment.
- Alveoloplasty not in preparation for dentures. The Agency only pays for alveoloplasty in preparation for dentures.
- Upcoding adult prophy to scaling and root planing.
- Billing for services not rendered.
- Billing limited oral evaluations inappropriately.

Summary of Common PIA Findings

- Documentation
  - Missing
  - Insufficient
- Telehealth issues
  - Medically unlikely procedures being billed
  - Telehealth visits not meeting requirements
- Upcoding and unbundling codes, includes but not limited to:
  - DRG
  - Procedures (CPT, CDT)
  - Level of service (E/M)
  - Level of care (inpatient vs outpatient)
  - Using EPA Codes without satisfying the EPA criteria
- Non-covered services
- Over the limit
- Unbundling services
  - Services that are included in an all-inclusive payment are billed separately from the bundled payment.
  - Services normally performed in one visit that are split up. Must document clinical need for not being performed in the same visit, even when split between different days.
- Services not rendered

Opportunities for Improvement

What can providers do to decrease the chances of having findings in an audit?

- Follow the appropriate billing guides
- Follow appropriate coding rules
- Bill the appropriate units
  - Units can be related to time or quantity or activities
- Never bill for two procedure codes that cover the same service
- Always document everything. “If it’s not documented, then it didn’t happen.”

- Expedited Prior Authorization (EPA) codes and Modifier codes have requirements. If the requirements aren't met, don't bill with the EPA or Modifier.

Suspected Fraud

If we suspect fraud, we will send a referral to our fraud investigators. Investigations, like most program integrity activities, also have a unique focus, schedule, and methods as follows:

- Focus is any provider, service, or MCO
- Based on referrals or complaints
- Involves research into provider background and billing patterns, data and records review, interviews, potential onsite visits, etc.
- Credible allegations of fraud referred to Medicaid Fraud Control Unit
- Payment suspension may be invoked

Referrals by PI

If an audit, clinical review, utilization review, or investigation identifies potential fraud, or a licensing or quality issue, the case will be referred to the appropriate oversight authority, which includes but is not limited to:

- Medicaid Fraud Control Division
- Department of Health
- Other law enforcement agency (e.g., U.S. Department of Health and Human Services Office of Inspector General)

Resources

- HCA Program Integrity webpage
- Washington State Program Integrity WAC-182-502A
- Federal False Claims Act 31 USC Sections 3729-3733
- Administrative Remedies for False Claims and Statements 31 USC Sections 3801 et seq
- CMS Guidance to States regarding False Claims Act (2020)
- State Laws
- Washington Medicaid Fraud False Claims Act RCW 74.66

Contact Information

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