Washington State Health Care Authority

Combatting Fraud, Waste, and Abuse

PI Educational Webinar – June 6, 2018

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Objectives of Webinar

1. Regulatory requirements for training and education
2. Overview of Apple Health Programs
3. Information on the scope of fraud, waste, and abuse (FWA)
4. Obligation of everyone to detect, prevent and correct FWA
5. Information on how to report FWA
6. Information on laws pertaining to FWA
7. Common audit findings related to FWA

Annual Training and Education

In July 2017, House Bill 1314 became law under RCW 74.09.195 which mandates HCA to:

- Conduct annual training and education with
  - Summary of audit results,
  - A description of common issues,
  - Problems and mistakes identified through audits and reviews, and
  - Opportunities for improvement.

Health Care Agency (HCA)

- The Single State/Medicaid Agency for Washington
- Responsible for administering Medicaid, Children's Health Insurance Program (CHIP), and state-only funded programs – collectively known as Apple Health (AH)
  - Shared responsibility with Department of Social and Health Services as of July 1, 2011
- Contracts with 5 Managed Care Organizations for majority of programs/services

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Medicaid

- Medicaid is jointly funded by state and federal governments
- Medicaid is authorized by Title XIX of the Social Security Act and became law in 1965
- Provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities

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CHIP

- Children's Health Insurance Program (CHIP) is jointly funded by state and federal governments.
- CHIP is authorized by Title XXI of the Social Security Act and became law in 1997.
- Provides health coverage to children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage.

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One State Medicaid Program is… One State Medicaid Program

- States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines.
- Federal law requires states to provide certain “mandatory” benefits and allow states the choice of covering other “optional” benefits.

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Mandatory Medicaid Benefits

- Inpatient & Outpatient Hospital
- Physician
- Laboratory and X-ray
- Home Health
- Nursing Facilities
- Rural Health Clinics
- Federally Qualified Health Centers
- Early & Periodic Screening, Diagnostic, & Treatment (EPSDT)
- Family Planning
- Nurse Midwife
- Nurse Practioner
- Birth Center
- Transportation
- Tobacco Cessation for Pregnant Women

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Optional Benefits in Washington

- Prescription Drugs
- Physical & Occupational Therapies
- Speech, Hearing & Language Disorder Services
- Respiratory Therapies
- Podiatry
- Optometry & Eyeglasses
- Dental & Dentures
- Other Diagnostic, Screening, Prevention & Rehabilitative Services
- Prosthetics
- Chiropractic
- Hospice
- Private Duty Nursing
- Personal Care, including Self-Directed Personal Assistance

Optional Benefit/Program Funding

Medicaid Waivers - Social Security Act Sections

- 1915 – Home & Community-Based Services
- 1115 – Expand Eligibility, Simplify Enrollment, or Reform Care Delivery

State-only funding:

- Alien Emergency Medical Program
- Medical Care Services Program
- Kidney Disease Program

Apple Health Programs

https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/scope-care

- HCA provides funding for a wide range of medical services. The level of medical coverage for any given client depends on the Medical Program for which the client is eligible.
- Some services may require prior authorization from the agency, an agency-contracted MCO, or the Department of Social and Health Services (DSHS), as applicable.
- Most clients are enrolled directly into an MCO with assigned PCPs. Exemptions – need for continued care with an established treating provider; status as and American Indian/Alaska Native; living in a county where managed care participation is voluntary (all counties will be managed care by 2021).

Protecting Apple Health/Medicaid

- Reducing improper payments is a critical element in protecting the financial integrity of Medicaid across the Nation.
- Protecting Medicaid from fraud, waste, and abuse is an “urgent priority” of the Federal government – testimony to US Congress in April 2018 by members of US Department of Health and Human Services Centers for Medicaid and CHIP Services (CMCS) and Office of Inspector General (OIG), and the Government Accountability Office (GAO).

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Definitions – Fraud, Waste & Abuse (FWA)

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.

Waste – includes overutilization of service or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program.

Abuse – provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid Program, or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

The Scope of FWA

HCA is federally mandated to protect the "integrity" of Apple Health programs

- This work is conducted within the Section of Program Integrity (PI) and other integral areas of the agency.
- PI conducts various activities in an effort to identify and prevent FWA and improper payments.

HCA PI Mission

Provide reasonable and consistent oversight of Apple Health programs and contracts to effectively encourage:

- Efficiency
- Compliance
- Accountability
- Protection of Public Funds
- Awareness and Responsibility

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HCA PI Goals

- Ensure the integrity of Apple Health programs
- Maintain accountability and effective stewardship
- Safeguard and protect public funds
- Reduce and eliminate fraud, waste and abuse in Apple Health programs
- Promote awareness and responsibility

HCA and Apple Health providers and contractors share a joint responsibility and a common set of PI goals

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Improper Payments

Waste

Errors

- **Incorrect** Coding

Inefficiencies

- Ordering **Excessive** Diagnostic Tests

Abuse

Bending the Rules

- Improper Billing Practices like Misusing Codes, such as **Upcoding** or **Unbundling** Codes

Fraud

Intentional Deceptions

- **Billing** for Services, Supplies, Equipment or Drugs that were **Not Provided**

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PI Activities (PIAs)

Activities conducted to identify fraud, waste and abuse, and improper payments in fee-for-service and managed care. Examples of PIAs:

- Audits, pre- and post-payment
- Clinical Reviews, pre- and post-payment
- Utilization Reviews
- Data Analytics/Algorithms
- Provider Site Visits
- Investigations of Potential Fraud
- Education and Outreach
- Client Eligibility and Utilization

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PI Audits

- Focus - any provider, service or MCO
- Routinely scheduled or based on referrals or complaints, or outliers identified through data mining
- Pre-payment are conducted after services are rendered and prior to payment of claim
- Post-payment are conducted after services are rendered and after payment of claim

PI Clinical Reviews

- Primary Focus – Inpatient Hospital (DRG coding validation, level of care, length of stay, provider preventable conditions, 14 day readmissions)
- Based on screening criteria, referrals or complaints, or outliers identified through data mining
- InterQual® Level of Care criteria used to determine appropriate level of care and length of stay

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PI Utilization Reviews

- Focus - any provider, service or MCO
- Based on referrals or complaints, or outliers identified through data mining
- Examples of data mining finds:
    - Spike in utilization or billing patterns of a specific provider
    - Duplicate, inconsistent, or excessive visits in relation to diagnoses

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PI Data Analytics/Algorithms

- Focus - any provider, service or MCO
  - One service and multiple providers versus audit/clinical review focus on one provider and multiple services
- Based on referrals or complaints, outliers identified through data mining, or identified system edit/policy vulnerabilities

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Tribal Compliance Monitoring

- Program directed at Indian Health Service and Tribal clinics to implement internal compliance monitoring and offer technical assistance when improper payments are discovered.
- Provides education in proper documentation and recordkeeping.
- All 29 Tribes are visited in a 3-year cycle, unless there is an identified risk of public health and safety, or fraudulent practices.

PI Timelines

- HCA issues a 30 day notice of intent to audit or record request with 30 day due date
- HCA issues draft/preliminary findings within 120 days from receipt of all information needed to conduct the audit or review
- Provider has 30 days from receipt of draft/preliminary to dispute the findings and/or request a Dispute Resolution Conference

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PI Timelines (cont'd)

- Provider has 28 days from receipt of final notice to formally appeal any overpayments
- Provider has 20 days from receipt of final notice or from the date all administrative remedies are exhausted, if applicable, to refund overpayments
- If applicable, provider must submit correct claims within 60 days from receipt of Remittance Advice indicating refund applied to improperly paid claims

PI Disputes and Appeals

- The informal dispute process is governed by WAC 182-502A-0801 and includes:
  - An opportunity to request a Dispute Resolution Conference
  - Additional time to gather information in support of a claim or encounter identified as a PIA finding
- The formal appeal process is governed by WAC 182-502A-0901, chapter 182-526 WAC and chapter 34.05 RCW
  - A formal request for administrative hearing must be received within 28 days from receipt of a final PIA Notice.

Improper Payment Resolution

There are several options to refund improper payments including a negotiated re-payment plan. Options are identified in the final notice and may include:

- Refund by check to HCA;
- Refund by check to HCA, HCA applies cash receipt to improperly paid claim(s), then provider submits correct claim(s), if permitted;
- Claim adjustment(s) or withhold of future payment(s) through the ProviderOne payment system; or
- Collection by the Office of Financial Recovery

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PI Investigations

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

Provider Site Visits

Per Federal regulation, conducted on high and medium risk providers to ensure provider business is operational. Site visit occurs during:

- Initial provider enrollment process, and
- Revalidation – every 5 years

PI Referrals

If any PIA identifies potential fraud, and/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 Unit
- Department of Health
- Other Law Enforcement Agency, i.e., HHS-OIG, local law enforcement entity

Client Eligibility and Utilization

- Public Assistance Reporting Information System (PARIS) and Interstate Match
  - Identifies clients residing and receiving Medicaid benefits in other states
- Veteran's Benefit Enhancement
  - Identifies Veteran's who are on Apple Health and qualify for additional Veteran's benefits (long-term care services) or who aren't currently connected with Veteran's benefits

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Patient Review & Coordination (PRC)

- Program for clients identified as over-utilizing services*
- The client is assigned to specific provider(s) – one or more of the following
  - Primary care provider
  - Pharmacy
  - Hospital for non-emergency care
  - Narcotic prescriber
- The provider(s) are chosen by the client or assigned by the program.

*Clients in the PRC Program show a 33% decrease in ER use, 37% decrease in office visits, and 24% decrease in prescriptions. Many PRC clients also seek/agree to behavioral health treatment while in the program.

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How to Refer a Client to PRC

- Send a Patient Review and Coordination Referral Form (13-840) by email to PRR@hca.wa.gov or to:

  PRC/PI
  P.O. Box 45503
  Olympia, WA 98504-5503

- Or – Fax to 360-586-0212
- Or – Call 800-562-3022 ext. 15606

Additional information about the program is at http://www.hca.wa.gov/PRC. Clients can access information about the program at https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/patient-review-and-coordination-0.

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Most Common PIA Findings

- Documentation to support billed service
  - Missing
  - Insufficient
- Upcoding of diagnoses, procedure(s) or service(s), including but not limited to:
  - Inpatient DRG / Outpatient APC
  - Procedures (CPT, CDT)
  - Level of Service (E/M)
  - Level of Care (inpatient vs outpatient)
- Unbundling – global codes, combination codes
- Non-covered services, including but not limited to:
  - Over the limit (units, time)
  - Exclusions
- Services not rendered, aka phantom billing

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Documentation Pitfalls

- No documentation, missing record of service –
  "If it's not documented, it's not done."
- Documentation is insufficient to support the level of service or level of care
- Missing dates, times, units, signatures for authentication
- Incorrect dates, units, procedures, diagnosis, medication, etc.
- Copy/paste in electronic health/medical records
- Good documentation promotes patient safety

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Upcoding & Unbundling

- Upcoding – using a higher level code, charging more for a service or item than is required
- Unbundling – billing separately for services covered in a full service fee, e.g., billing separate codes for a surgery and a follow-up visit the next day when on global code already includes both services, billing separate labs or x-rays when a combination code exists for multiple tests/views

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Improper Pharmacy Billing

- Billing for non-existent prescriptions
- Billing HCA as primary when a client has private insurance – other coverage code 8 vs 2
- Billing brand name with generics are dispensed
- Billing for non-covered prescriptions as covered items
- Billing for prescriptions that are never picked up
- Splitting prescriptions to receive additional dispensing fees

Improper Billing – Equipment & Supplies

- No delivery documents
- No prescription or prescription without a valid signature or date
- Billing higher level equipment than ordered
- Billing higher units than ordered or allowed
- Billing before the order date
- Billing with an outdated prescription/order
- Billing with copy/paste information

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Examples of Client Fraud

- Identity Theft
- Misrepresentation of eligibility status
- Resale of drugs, durable medical equipment, medical supplies

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Fraud Schemes

- Billing for appointments the patient failed to keep
- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the record
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Paying for referrals of Medicaid clients or giving clients money or gifts for Medicaid ID and billing for false services

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Abusive Billing

- Billing for unnecessary medical services
- Charging excessively for services, equipment or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes
- Billing under the wrong NPI

The difference between abusive billing and fraudulent billing is intent.

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Tips for Accurate Billing

- Accurate documentation not only supports accurate billing, it promotes good quality of care which enhances patient safety
- Use correct code, not a code that offers highest reimbursement
- No cloning - electronic health records must be completed for each visit, no copy/paste from previous visits
- Authenticate records with date/time and signature
- Ensure delivery documents are signed upon delivery
- Bill accurate number of units
- Protect your prescription forms from being stolen

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The Effects of FWA

- Increased health care costs due to costs of fraudulent expenses
- Increased burdens on federal, state and local tax funds
- Reduced available funds to pay for legitimate necessary health care services
- Reduced levels of service available to beneficiaries due to increased levels of audit and security

Internal Compliance Program

- Goal: Prevent potential fraud, waste and abuse AND improper payments
  - Compliance Officer
  - Policies and Procedures
  - Training for providers and staff
  - Methodology that encourages staff to report potential problems
  - Prompt review of reported problems and initiation of corrective action(s)
- Provider Self-Audit, WAC 182-502A-0501

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What is your responsibility?

- Conduct regular compliance audits and report any overpayments to HCA PI
- Review Remittance Advices from HCA and ensure payments are reconciled against general ledgers
- Report any concerns, suspected or known violations on the part of a provider, client or another employee.

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How to Report?

- Report a suspected violation to your Compliance Officer who will begin an investigation; and
- Contact HCA HotTips at
  - 1-800-562-6906; or
  - hottips@hca.wa.gov
- For client eligibility fraud – report to:
  - 360-725-0934
  - WAHEligibilityFraud@hca.wa.gov

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Potential Penalties

Aside from refunding improper payments:

- Providers who violate healthcare fraud laws could face exclusion from federal healthcare programs and civil monetary penalties – treble damages.
- Prosecution of fraud can lead to prison time and termination from Medicaid program.
- Clients who commit fraud are terminated from the program and face criminal prosecution.

State and Federal Regulations

- Chapter 182-502A WAC - Program Integrity
- Chapter 182-501 WAC
- Chapter 182-502 WAC
- Chapter 41.05A RCW
- Chapter 74.09 RCW
- 42 CFR Parts 431, 433, 438, 455, 456, 495, 1001

State Medicaid False Claims Act

- Established in March 2012 under Chapter 74.66 RCW
- Similar to Federal False Claims Act
- Imposes liability on any person or corporation who knowingly presents a false or fraudulent claim to the Washington Medicaid program, misappropriates public property or improperly avoids or decreases an obligation to a Washington State Medicaid Agency.
- Medicaid Fraud Control Unit within the Office of Attorney General has law-enforcement and prosecutorial authority.

Federal False Claims Act

A federal statute that covers fraud involving any federally funded contract or program, including Medicare and Medicaid programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the US Government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information on a claim.

Deficit Reduction Act

This Act aims to cut fraud, waste and abuse from Medicaid programs.

- Any healthcare entity who receives payment of at least $5 million in Medicaid funds per year must:
  - Have written policies that inform employees, contractors, and agents of the following:
    - Education about the Federal False Claims Act and state laws pertaining to false claims;
    - A process for employees and others to report fraud, waste and abuse;
    - Employee protection rights as whistleblowers.

Anti-Kickback Statute

- 42 U.S.C. x. 1320a-7b(b)
- It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services paid in whole or in part by a federal health care program. “Remuneration” includes transfer of anything of value, directly or indirectly, overtly or covertly, in case or in kind.

Self-Referral Prohibition Statute

- 42 U.S.C. s. 1395nn
- The "Stark Law" prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his/her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Preparing for an HCA Audit or Review

- Understand HCA's obligation to audit/review
  - An audit or review can identify vulnerabilities in a system or process and/or improper payments
  - Federal regulations for prevention and identification of fraud, waste, & abuse, and recovery of improper payments
- Ensure all requested information is provided and in electronic format
- Ask questions as needed
- Pay attention to deadlines and if necessary, request an extension
- Refer to chapter 182-502A WAC and provider guides

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Other Audit/Review Entities

- Managed Care Organizations
- Medicaid Recovery Audit Contractor (RAC)
  - Federally required, State contractor
- State Auditors Office (SAO)
- HHS-CMS Contractors
  - Payment Error Rate Measurement (PERM)
  - Unified Program Integrity Contractor (UPIC)
- HHS-Office of Inspector General (OIG)

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More Educational Resources/Links

- New PI Educational Handbook + PI Webpage – 7/1/18
  - https://www.hca.wa.gov/about-hca/program-integrity
- Program Administration
  - https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration
- Billers and Providers – Programs and Services
  - https://www.hca.wa.gov/billers-providers/programs-and-services
- Forms and Publications
  - https://www.hca.wa.gov/free-or-low-cost-health-care/forms-and-publications
- CMS – Medicaid Education Toolkits
  - https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/medicaid-toolkits-overview.pdf

Questions?

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