Washington State Health Care Authority

Program Integrity Annual Education

Disclaimer

The information provided in this educational intervention is not intended to serve as an exhaustive or detailed account of all legal requirements pertinent to compliance with Medicaid program integrity laws and regulations. The Health Care Authority (HCA) encourages all providers and entities to consult with their legal counsel, Board of Directors, or other business advisors regarding compliance with Medicaid laws and regulations.

Program Integrity Annual Education

Learning Objectives

This training document will cover the following areas:

- The audit process.
- Audit sampling techniques.
- General program integrity overview and activities.
- Summary of 2023-2024 audit results and description of common findings.
- Procedures for providers involved in HCA audits.
- Areas of interest.

HCA Program Integrity

Program integrity is federally mandated to protect the integrity of Apple Health (Medicaid) programs. It involves identifying, preventing, and investigating potential fraud, waste, and abuse within Apple Health. Credible allegations of fraud are referred to the Medicaid Fraud Control Division (MFCD) or other law enforcement agencies. Reviews of HCA paid claims and Managed Care Organization (MCO) encounters claims ensure that Apple Health funds are utilized appropriately.

Law Requiring Annual Training

Effective in 2017, RCW 74.09.195: Audits of Health Care Providers by the Authority required that the HCA provide annual training for providers, which include:

- Summary of Audit Results: Providers need to be informed about the main findings from audits.
- Description of Common Issues: Training should cover common problems that audits have identified.
- Identification of Problems and Mistakes: It should highlight typical mistakes and issues found through audits and reviews.
- Opportunities for Improvement: The training should point out ways providers can improve to avoid these problems.

HCA Program Integrity's Audit Process

A thorough understanding of the HCA's audit process can help providers prepare effectively.

Step-by-Step Process:

Notification: Providers receive an audit notification outlining the scope, focus and objectives, often accompanied by a records request list.

Preparation: Providers gather necessary documentation and records for the audit.

Fieldwork/Deskwork: Auditors review and analyze records, conduct interviews, and observe practices if necessary.

Report: A preliminary report is issued, highlighting findings and areas of concern. Under some circumstances a final report may be issued without issuing a preliminary report.

Response: Also known as the Informal Dispute Resolution (IDR) process, where providers can respond to findings and provide additional information. Providers may also request an IDR conference.

Final Report: A final report is issued, incorporating provider responses and outlining corrective action plans. Outcomes may include provider education and establishment of final debt or improper payment.

Educational Intervention

Educational intervention involves agency-provided education to an entity either prior to or following an agency-initiated program integrity review that has identified an adverse determination. It includes notices of adverse determinations issued by the agency or any agency provided training that has not corrected the level of payment error.

Sustained High Level of Payment Error

A sustained high level of payment error is defined as a net payment error rate equal to or exceeding five percent for the audit period. This could put providers at risk for future focused or extrapolated audits.

How Providers Are Selected for Audits

Referral or Allegation

The HCA may receive statements regarding a provider from various sources such as employees, relatives of the provider, other agencies, or within the HCA itself. Upon receiving such statements, the HCA is obligated to follow up by vetting the lead through claims data analysis and/or requesting relevant records.

Data Mining

Medicaid program integrity data mining utilizes advanced data analysis techniques to detect and prevent fraud, waste, and abuse within the Medicaid program. This involves gathering data from multiple sources, including Medicaid claims, provider enrollment information, and other relevant databases. Through data mining, patterns, anomalies, and trends that may indicate fraudulent activities are identified. Techniques such as predictive analytics are used to forecast potential future occurrences of fraud and assess risk levels. Commonly identified issues include pattern recognition of suspicious billing practices, such as unusually high billing rates, duplicate claims, or services not rendered.

Scheduled Audits

The primary objective of scheduled audits is to ensure the integrity of the Medicaid program by verifying that payments are made only for legitimate, medically necessary services. These audits help protect taxpayer funds and ensure resources are available for those who truly need them. Scheduled audits are performed regularly, often on an annual or biennial basis, depending on the provider's size, claim volume, and audit history. These audits are vital for maintaining the efficiency and effectiveness of the Medicaid program.

Audit Sampling

Focused Audit Sampling involves selecting a specific subset of claims or transactions for review based on criteria or risk factors. This method targets areas more likely to contain errors or fraudulent activities. Auditors identify specific risk factors, such as high billing rates, unusual patterns, or a history of compliance issues, and select a sample based on these factors. The sample size may vary depending on the level of risk.

Extrapolation Techniques use statistical methods to estimate the extent of errors or overpayments in a larger population based on a sample audit's results. This method is especially useful for auditing large claim volumes. A random sample of claims is selected from the entire population submitted by a provider. This sample is audited to identify errors or overpayments. Statistical analysis of the sample audit results is then used to project findings to the entire population.

For more details on extrapolated audits, refer to:

WAC 182-502A-0601 Extrapolation, and
WAC 182-502A-0201 Definitions – Educational Intervention.

Program Integrity Activities

Program integrity activities from CY 2023 – 2024 included:

- Pre- and post-payment program integrity audits
- Audits and reviews (hospital, pharmacy, dental, school-based services, and other outpatient services)
- Utilization review
- Data analytics
- Investigation of fraud allegations
- Education and outreach

Summary of Audit Results, Common Issues, and Areas for Improvement

Over the past year, numerous audits across various providers have highlighted significant trends and areas requiring attention. While many providers show strong compliance commitment, recurring issues still need addressing.

Hospital Audits:

- Provider preventable conditions and healthcare-acquired conditions.
- Inpatient hospital readmissions.
- ER visits billed within one day of an inpatient admission.
- Alien Emergency Medical (AEM) claims not covered by the Alien Medical Program.
- Inadequate documentation supporting service levels or quantities ordered.
- Missing or incomplete medical records.
- Unbundling charges or billing non-separately billable items.
- Billing for non-covered services or services not rendered.

Dental Audits:

- Fluoride treatment exceeding limits.
- Inappropriate use of CDT D0140, Limited oral evaluations, billed with:
    - Routine scheduled dental service.
    - As a post-op evaluation.
- Inappropriate use of CDT D9110, Palliative treatment. Did not follow provider billing guides/instructions:
    - Missing tooth number with claims submission.
    - Billed in conjunction with teeth extractions.
    - Claim not submitted with CDT D0140, Limited oral evaluations.
- Silver diamine fluoride treatment.
    - Missing patient consent form.
- Documentation not supporting billed services.
    - Complex extraction vs. Simple extraction.
- Periodontal scaling and root planning (PRSP).
    - Four quadrants completed in one visit/appointment.
- Billing for drugs dispensed where prescriptions were also written for patient home-use.
- Billing for Orthodontic reevaluation after braces were placed.
- Dental assistant performing extractions and restorations.

- Federally Qualified Health Centers (FQHC) splitting services into multiple encounters when some services could be rendered in a single visit.

MCO Network Provider Audits:

- DRG code validation for inpatient hospitals.
- Billing for services not rendered.
- Ensuring medical records support billed services.
    - Excessive billing for individual psychotherapy (CPT code 90837).
    - Upcoding for higher-level visits.
- Inappropriate use of HCPCS code Q3014, originating site.
    - Telehealth services when patients and/or their physician is not located at the originating site.

Common Issues: Identifying common issues helps providers improve practices and avoid pitfalls.

- Coding Errors: Ensure accurate coding aligns with provided services.
- Insufficient Documentation: Maintain thorough records supporting billed services.
- Incorrect Billing Practices: Avoid billing for non-rendered, duplicate, or non-covered services.

Problems Identified:

- Lack of training or updates on billing and coding standards.
- Misunderstanding of policy requirements and the HCA's provider billing guides.
- Inadequate internal audits.

If Your Practice or Office is Audited

Preparation and knowledge are key to a smooth audit process.

Suggestions:

- Know Your Auditor: Understand the agency, their role, purpose, and scope for the audit.
- Preparation: Maintain complete, accurate documentation. Regularly train staff on current policies and coding guidelines. Conduct internal audits proactively.
- During the Audit: Be cooperative, transparent, and responsive. Ask questions and provide accurate information promptly. Maintain open communication, particularly if additional time is needed to fulfill the auditor's request.
- Post-Audit: Review findings, implement corrective actions, and use the experience to improve practices.

Note: Do not fabricate incomplete or missing records. Do not adjust or modify claims in the ProviderOne system, particularly claims or services that are part of the ongoing audit.

Suspected of Fraud and Referrals by Program Integrity (PI)

Suspected fraud results in referral to fraud investigators, focusing on providers, services, or MCOs. Investigations involve background research, data review, interviews, and potential onsite visits.

Credible allegations of fraud are referred to the Medicaid Fraud Control Division (MFCD) of the Washington State Attorney General Office, potentially leading to payment suspension, prosecution and/or other enforcement actions.

If audits or reviews identify other issues besides or in addition to potential fraud, cases are referred to appropriate oversight authorities, including:

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

Increasing Areas of Concern and Potential for Future Audit

- Applied Behavior Analysis (ABA) Services:
  - Billing for non-medically necessary services: Providers may submit claims for services that are not medically necessary or did not occur.
  - Up-coding: Billing for higher-level services than were provided.
  - Concurrent billing: Submitting claims for multiple services rendered at the same time.
- Non-emergency Medical Transportation (NEMT):
  - Billing for non-existent trips: Providers may bill for trips that were never provided.
  - Unauthorized drivers or vehicles: Using drivers or vehicles that are not authorized or properly licensed.
  - Transporting individuals who are not eligible for NEMT services.
- Personal Care Services (PCS):
  - Billing for services not rendered: Providers may bill for services that were never performed.
    - Patients were admitted to a hospital or who have passed away, but services continue to be billed.
  - Instances of abuse or neglect by personal care provider.
  - Coordinated efforts to defraud the system involving multiple individuals.
- DNA Laboratory Tests:
  - Ordering tests that are not medically necessary.
  - Altering or misrepresenting test results for financial gain.
  - Offering or accepting incentives for referrals.
- Electronic Visit Verification (EVV):
  - Falsifying records show that services were provided when they were not.
  - Exploiting vulnerabilities in the EVV system to bypass verification.
- Telehealth Services
  - Billing for telehealth services that were not provided or were not medically necessary.
  - Using stolen patient information to bill for telehealth services.
  - Exploiting differences in state telehealth regulations to commit fraud.
- Behavioral Health Services:
  - Submitting claims for more sessions than were conducted.
  - Exploiting relaxed telehealth regulations to bill for services not rendered.
  - Cloning records

Resources

Some of the resources you should be familiar with include, but are not limited to:

- HCA Program Integrity webpage
- HCA Program Integrity regulations Chapter 182-502A WAC
- Washington State Laws including Washington State Medicaid Fraud False Claims Act in chapter 74.66 RCW
- Federal False Claims Act 31 USC Sections 3729 – 3722
- Administrative Remedies for False Claims and Statements 31 USC Sections 3801 et seq

CMS Guidance to States regarding False Claims Act (2020)

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