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August 2010

Fraud & Abuse in Tennessee

- TennCare Fraud
  - “It’s a simple message that we are carrying across the state- if you lie, cheat or steal drugs or medical services paid for by TennCare, you risk going to jail or prison.”

    (Inspector General Deborah Y. Faulkner)
    (Source:http:news.tennesseeanytime.org/node/4584)
  - http://news.tennesseeanytime.org/taxonomy/term/65

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Topics for Today's Presentation

- Development of Program Integrity, Laws & Requirements
- Current Audit Activities
- Preparing for an Audit
- Basic Documentation Requirements

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Key Terms

- **Fraud** – *Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit*
  - *Most Medicaid payment errors are billing mistakes and are not the result of someone such as a physician, provider, or pharmacy trying to take advantage of the Medicaid Program*
  - *Fraud occurs when someone* ***intentionally*** *falsifies information or deceives the Medicaid Program*

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Key Terms (cont.)

- **Waste** – *Thoughtless or careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems or controls*

- **Abuse** – *Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards*

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Key Terms (cont.)

- **Compliance Program** – S*ystematic procedures instituted to ensure that contractual and regulatory requirements are being met*
- **Compliance Risk Assessment** – P*rocess of assessing a company's risk related to its compliance with contractual and regulatory requirements.*
- **Compliance Work Plan** – *Prioritization of activities and resources based on the Compliance Risk Assessment findings*
- **Program Integrity** – *Steps & activities included in the compliance program & plan specific to fraud, waste & abuse*

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Development of Program Integrity, Laws & Requirements

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History of Program Integrity

- Balanced Budget Act (BBA)
  - Amended Social Security Act (SSA) re: Healthcare Crimes
  - Must Exclude from Medicare & State Healthcare Programs those Convicted of Healthcare Offenses
  - Can Impose Civil Monetary Penalties for Anyone Who Arranges or Contracts with Excluded Parties
- Federal False Claims Act (FCA)
  - Liable for a Civil Penalty of Not Less than $5,000 & No More than $10,000, Plus 3x Amount of Damages for Those Who Submit, or Cause Another to Submit, False Claims
  - TN False Claims Act (4-18-101 et seq.) – Liable for a Civil Penalty of Not Less than $2,500 & Not More than $10,000 for Each Violation
- Deficit Reduction Act (DRA)
  - Requires Communication of Policies & Procedures to Employees re: FCA, Whistleblower Rights and Fraud, Waste & Abuse Prevention, if Receiving More than $5M in Medicaid

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History of Program Integrity (cont.)

- 7 Basic Elements of a Compliance Program as Adopted by OIG & CMS (based on Federal Sentencing Guidelines)
  - Written Policies & Procedures
  - Compliance Officer & Compliance Committee
  - Effective Training & Education
  - Effective Lines of Communication between the Compliance Officer, Board, Executive Management & Staff (incl. an Anonymous Reporting Function)
  - Internal Monitoring & Auditing
  - Disciplinary Enforcement
  - Mechanisms for Responding to Detected Problems

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New 8th Element of a Compliance Program

- Compliance Programs Must be Effective
  - Must Show that Compliance Plans are More than a Piece of Paper
  - Must Be Able to Show an Effective Program that Signifies a Proactive Approach to the Identification of Fraud, Waste & Abuse
  - How Much Fraud, Waste & Abuse Have You Identified?
  - How Much Fraud, Waste & Abuse Have You Prevented?

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Regulatory Changes = Heightened Federal & State Awareness

- Laws & Regulations are Now Formalizing & Emphasizing the Effectiveness in Prevention, Detection & Resolution of Fraud, Waste & Abuse as well as the Recovery of Overpayments

- Fraud Enforcement and Recovery Act of 2009 (FERA)
  - Amends the FCA Intent Requirement – A False Statement Need Only be "Material to" a False Claim
  - FCA Now Prohibits Knowingly Submitting a Claim for Payment Known to be False or Fraudulent; Making/Using a False Record Material to a False Claim or to an Obligation to Pay Money to the Government; Engaging in a Conspiracy to Defraud by the Improper Submission of a False Claim; or Concealing, Improperly Avoiding or Decreasing an Obligation to Pay Money to the Government

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Regulatory Changes = Heightened Federal & State Awareness (cont.)

- Patient Protection and Affordable Care Act (**PPACA – Healthcare Reform Act**)
  - Expands Audits & Government Programs & Requires Providers to Return Overpayments within 60-Days of Identification
  - Increases Sentencing Guidelines for Healthcare Fraud, Makes Obstructing a Fraud Investigation a Crime & Makes it Easier for the Government to Recapture Funds
  - Enhances Provider Screening & Enrollment Requirements
  - Increases Funding to Prevent, Identify & Fight Fraud by $350M over the Next 10 Years

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Regulatory Changes = Heightened Federal & State Awareness (cont.)

- Patient Protection and Affordable Care Act (**PPACA – Healthcare Reform Act**)
  - Allows Federal Government Easier Sharing of Data, Identification of Criminals & Fraud Prevention
  - Requires Providers & Suppliers to Implement Compliance Programs
  - Enhances Penalties to Deter Fraud & Abuse through Stronger Civil & Monetary Penalties for Those Convicted of Fraud & Those Who Know of & Fail to Return an Overpayment (Up to $50,000 or Triple Amount of Overpayment)

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Current Audit Activities

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Types of Audits

- A **<u>Compliance</u>** audit is a comprehensive review of an organization's adherence to contractual and regulatory guidelines to evaluate the strength and thoroughness of its <u>compliance</u> preparations. Auditors review polices & procedures, internal controls and risk management procedures over the course of an audit.

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Types of Audits (cont.)

- A **Program Integrity** audit is a comprehensive review of an organization's adherence to contractual and regulatory guidelines to evaluate the strength and thoroughness of its efforts to prevent, detect and correct Fraud and Abuse.

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Types of Audits (cont.)

- A **Claims Billing** audit is a review of medical records and other relevant documents to determine whether the documentation supports payment of a claim for services.

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State Level Activities – Compliance & Integrity Departments

- Compliance Audits
- Fraud, Waste & Abuse Audits
- Special Investigation Unit (SIU) Audits

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Federal Level Activities – Centers for Medicare & Medicaid Services (CMS)

- Medicaid Integrity Program (MIP)
  - 1st Federal Strategy to Prevent & Reduce Fraud, Waste & Abuse
  - Hire Contractors to Review Medicaid Provider Activities, Audit Claims, Identify Overpayments and Educate Providers
  - Provide Support & Assistance to States in Efforts to Combat Medicaid Fraud, Waste & Abuse
- Medicaid Integrity Group (MIG)
  - Responsible for Implementing the MIP
- Medicaid Integrity Contractors (MIC)
  - Regional Contractors Hired through the MIP to Ensure Paid Claims were:
    - Properly Documented
    - Billed Properly, Using Correct & Appropriate Codes
    - For Covered Services & Paid According to Federal & State Laws, Regulations & Policies
  - Tennessee Office of Inspector General

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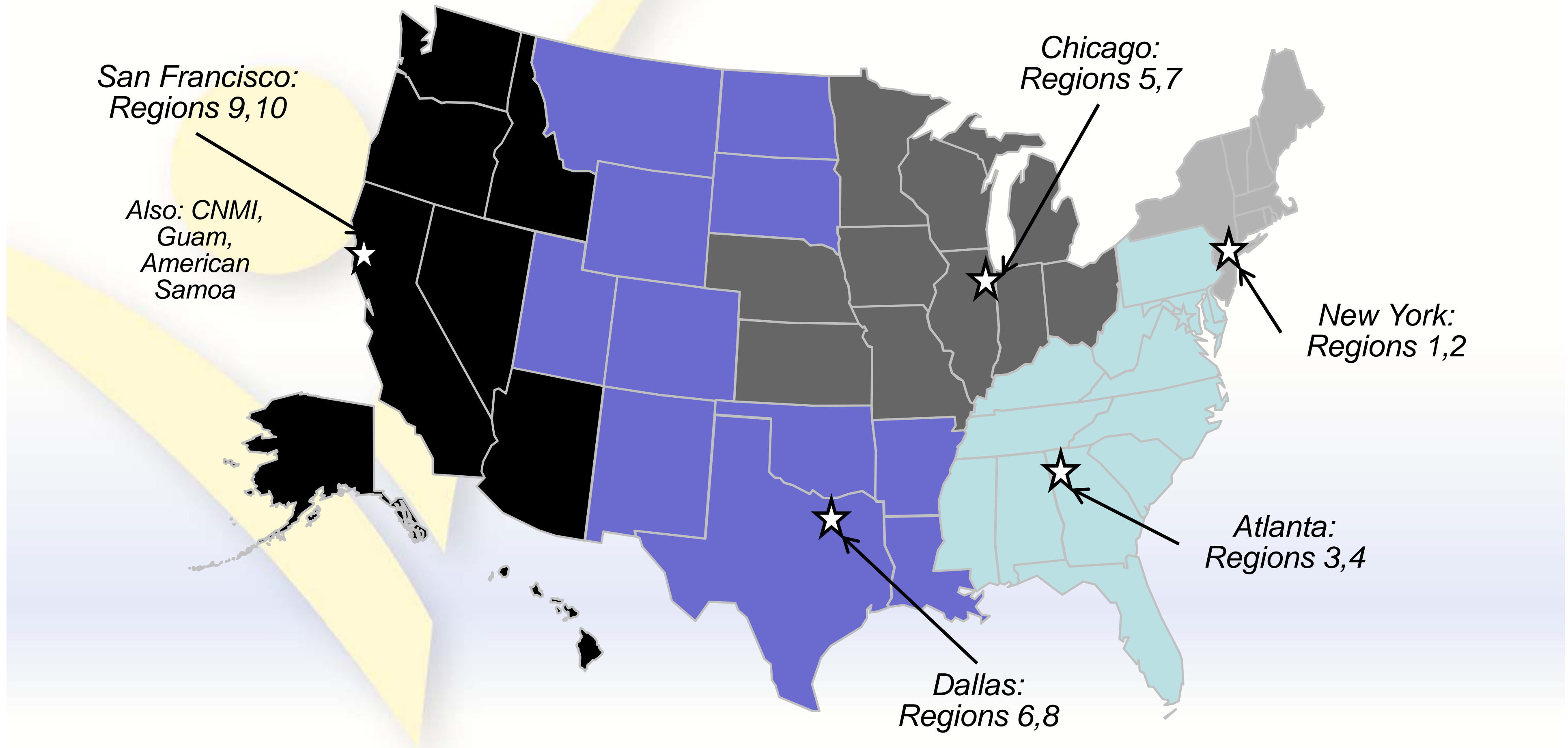
MIC Jurisdictions/Regional Offices



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Other Enforcement Entities

- U.S. Department of Health & Human Services, Office of Inspector General (OIG)
- U.S. Department of Justice (DOJ)
- Office of the State Attorney General (AG) – Medicaid Fraud Control Unit (MFCU)
- Federal Bureau of Investigation (FBI)
- Department of Insurance (DOI)

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ValueOptions' Approach

- The purpose of the Compliance program is to conduct business and interact with clients, members, providers and employees consistent with applicable laws, contractual obligations and ethical standards. Compliance is the responsibility of *all* employees.

- The purpose of Program Integrity is to support the government's goal to decrease financial loss from false claims and reduce ValueOptions® risk of exposure to criminal penalties, civil damages, and administrative actions.

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ValueOptions' Approach – Program Integrity Development Plan

- ValueOptions' Program Integrity Description
  - Compliance Plan & Oversight
    - Compliance Officer/Leads & Compliance Committees
  - Program Integrity Plan:
    - Prevention:
      - Industry Partnership
      - Training & Education
      - Provider Support
      - Contractual Provisions
      - Provider Profiling & Credentialing
      - Ethics Hotline
      - Claims Edits
      - Prior Authorizations
      - Member Handbook

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ValueOptions' Program Integrity Plan (cont.)

- Audit & Detection
  - Internal/External Referral Process
  - Audits
  - Post-Processing Review of Claims
  - Data Mining & Trend Analysis
  - Special Reviews

- Investigation & Resolution
  - Investigation & Disciplinary Processes
  - Reporting Requirements

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Prepare, You Will Be Audited

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Train Staff to Recognize Fraud, Waste & Abuse

- Common Fraud Schemes:
  - Billing for “Phantom Patients”
    - Ex: Billing for Members that Don’t Exist
  - **Billing for Services Not Provided**
    - **Ex: Billing for Member No-Shows, Billing for Time When the Member Is Not Present**
  - Billing for More Hours than In a Day
    - Ex: One Staff Person is Providing More than 24-Hours of Service within a Day
  - Using False Credentials
    - Ex: Signing Off as Having License When the Credentials Expired or Were Revoked
  - Double-Billing
    - Ex: Getting Paid the Maximum Allowable Amount for the Same Service by Two Different Funders

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Train Staff to Recognize Fraud, Waste & Abuse (cont.)

- Misrepresenting the Diagnosis to Justify the Service
  - Ex: Exaggerating Symptoms to Obtain More Services
- Misrepresenting the Type or Place of Service or Who Rendered the Service
  - Ex: Stating that the Service Was Performed at Your Facility When It Was Actually Provided at the Member's Home
- Billing for Non-Covered Services
  - Ex: Billing for Educational Groups or for Computer-Based Services
- Upcoding
  - Ex: Billing for Outpatient Individual Services Instead of Outpatient Group Services (the Service Actually Performed) in Order to Obtain More Money

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Train Staff to Recognize Fraud, Waste & Abuse (cont.)

- Failure to Collect Co-Insurance/Deductibles
  - Ex: Failing to Bill Another Health Insurance Before Billing Medicaid
- Inappropriate Documentation for Services Billed
  - Ex: Failing to Document a Progress Note Appropriately Supporting the Service that Was Billed
- Lack of Computer Integrity
  - Ex: Sharing Passwords with Staff
- Failure to Resolve Overpayments
  - Ex: Receiving Payment for Services Not Provided and Failing to Return the Funds to Medicaid
- Delays in Discharge to Run Up the Bill
  - Ex: Stating the Member Does Not Have a Place to Discharge to When Family is Available

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Train Staff to Recognize Fraud, Waste & Abuse (cont.)

- **Duplicate Documentation for Separately Billed Services**
  - **Ex: Same Note is Copied for the Same Member or for Different Members**
- Kickbacks
  - Ex: Making Arrangements with a Referral Source and Paying the Referral Source to Send Members to Your Facility

- Common Member Fraud Schemes:
  - Forgery
    - Ex: Staff or Members Signing Releases for Other Clients
  - Impersonation
    - Ex: Pretending to be the Person Who Has a Medical Card in Order to Receive Treatment

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Train Staff to Recognize Fraud, Waste & Abuse (cont.)

- Co-Payment Evasion
  - Ex: Failing to Tell the Assessor/Provider About Other Health Insurance
- Providing False Information
  - Ex: Misrepresenting Income
- Sharing or Theft of Medicaid Benefits
  - Ex: Members Sharing Identification in Order to Receive Treatment

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How Do We Do This?

- Use the 8 Elements of an Effective Compliance Program as a Guide
- Delegate a Knowledgeable Point Person
  - Appoint Someone Who Knows How the Various Parts of the Compliance Program Work Together and Who Can Address All Fraud, Waste & Abuse Activities When a MIC Shows Up for an Audit
- Know Your Contractual & Regulatory Requirements re: Fraud, Waste & Abuse
- Educate Staff on How Daily Activities Prevent, Detect & Address Fraud, Waste & Abuse
  - Be Sure to Have Staff Sign-Off that they Received the Training
- Maintain Documentation of All P&Ps, Activities, Audits, Investigations, etc. to Establish an Effective Compliance Program

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Establish an Environment of Awareness (cont.)

- Verify Member Eligibility
- Ensure Staff Know How to Report Fraud, Waste & Abuse
- Communicate Internally & Externally
- Educate & Train
- Set-Up a Suggestion Box for Anonymous Concerns and Suggestions for Improvement
- Post Fraud, Waste & Abuse Tips
- Send Out Weekly Tips on How to Prevent Fraud

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Establish an Environment of Awareness

- Provide Clinically Necessary Care through Services within the Scope of the Practitioners' Licensure
- Routinely Monitor Treatment Records for Required Standardized Documentation Elements
- Monitor & Adhere to Claims Submission Standards
- Correct Identified Errors
- Hold Staff Accountable for Errors
- Cooperate w/ All Audits, Surveys, Inspections, etc.
- Cooperate w/ Efforts to Recover Overpayments

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Conduct Self-Assessments

- Detail All Program Integrity Requirements & Contract Requirements
- Assess & Prioritize Gaps in Compliance & Develop Action Plans to Remedy = Document All Efforts
- Ask Yourselves Assessment Questions, such as:
  - Do We Have a System in Place to Identify When an Employee Lost His/Her Credentials?
  - Do We Have a System in Place to Ensure Treatment Record Documentation Meets Standards?
  - Do We Have a System in Place to Make Sure We Are Only Billing for Services Rendered and Documented Correctly & Accurately?
  - Do We Have a System in Place to Routinely Check Member Eligibility?
  - Do We Have a System in Place to Trains Staff and Hold Staff Accountable for Their Actions?

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Conduct Self-Assessments (cont.)

- Do We Have a System in Place to Make Sure Staff Correctly Document Start/Stop Times in Treatment Records?
- Do We Have a System in Place to Detect if Staff Are Letting Members Out Early but Documenting a Full Session Took Place?
- Can We Support All of These Systems/Processes through Appropriate Documentation in the Event of an Audit
- Are Our Processes Working? Are They Effective?
- What Evidence Can We Produce to Show They are Effective?

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Basic Documentation Requirements

"If It's Not Documented – It Didn't Happen"

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Purposes for Documentation

- Provides Evidence Services Were Provided
- Required to Record Pertinent Facts, Findings, & Observations About an Individual's Medical History, Treatment, and Outcomes
- Facilitates Communication & Continuity of Care Among Counselors & Other Health Care Professionals Involved in the Member's Care
- Facilitates Accurate & Timely Claims Review & Payment
- Supports Utilization Review & Quality of Care Evaluations
- Enables Collection of Data Useful for Research & Education

Basic Documentation Needs

- Start & Stop Times
  - Every Billable Activity Must Have a Service Start Time and Stop Time that Matches Time Billed
- Service Codes
  - Service Codes Submitted w/ Claims for Payment Must Match the Documentation in the Charts
- Individualized Progress Notes
  - Notes Must be Specific to the Members, Appropriately Support the Time, Type, etc. of Services Billed & Tie Back to Treatment Plans
  - The Members' Names Must be Included on All Notes
- Units Billed
  - Number of Units Billed Must Match Number of Units in Documentation
- Full Signatures w/ Credentials & Dates
  - All Documentation/Progress Notes Must be Signed & Include Credentials
- Covered vs. Non-Covered Services
  - Are Services Covered/Billable?

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Basic Documentation Needs (cont.)

- Service Definitions
  - Services Provided/Documented Must Meet the Service Definition for the Specific Code Billed
- Ensure Progress Notes are Legible
- Amendments
  - All Changes Must be Initialed & Dated, with Single Strike-Through Lines Made Through Changed Documentation

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Documentation – Additional Tips

- Activity Logs Should Not be Pre-Signed
- Progress Notes Must be Written After the Group/Individual Session
- All Entries Should be in Blue or Black Ink for Handwritten Notes, Not Pencil, No White-Out
- Keep Records Secure and Collected in One Location for Each Member

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Tennessee Rules and Regulations –

- For Facilities Licensed by TDMHDD
  - 0940-5-6-.05 (Client Record Requirements)
- Fraud & Abuse
  - http://michie.com/tennessee
- VSHP Provider Administration Manual

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Laws Regulating Fraud, Waste & Abuse

- False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
- Stark Law, Social Security Act, § 1877
- Anti-Kickback Statute, 41 U.S.C.
- HIPAA, 45 CFR, Title II, § 201-250
- Deficit Reduction Act (DRA), Public Law No. 109-171, § 6032
- Care Programs, 42 U.S.C. § 1128B, 1320a-7b
- False Claims Whistleblower Employee Protection Act, 31 U.S.C. § 3730(h)
- Administrative Remedies for False Claims and Statements, 31 U.S.C. Chapter 8, § 3801

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Program Integrity Links

- Code of Federal Regulation
  - TITLE 42-Public Health, Chapter IV-CMS, DHHS, SUBCHAPTER C-Medical Assistance Programs, Part 455-Program Integrity: Medicaid
  - www.gpoaccess.gov/cfr/index.html
- Office of Inspector General (OIG):
  - www.oig.hhs.gov/fraud.asp
- Center for Medicare and Medicaid Services (CMS):
  - www.cms.gov/MedicaidIntegrityProgram/
- National Association of Medicaid Fraud Control Units (NAMFCU):
  - www.namfcu.net/

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ValueOptions® Contact & Reporting Info:

- Ron Melzer, Ph.D., Director of Quality Management – Tennessee
  - 1-347-821-8553
- ValueOptions® Ethics Hotline
  - 1-888-293-3027
- Report Concerns to Your Organization's Compliance Office, ValueOptions® directly, or via ValueOptions' Ethics Hotline
  - Remember: You May Report Anonymously and Retaliation is Prohibited When You Report a Concern in Good Faith
  - Reporting All Instances of Suspected Fraud, Waste and/or Abuse is an Expectation and Responsibility for Everyone
- Tennessee (OIG) Fraud Division
  - http://www.tn.gov./tnoig/ReportTennCareFraud.html
  - Fraud Toll Free Hotline @ 1-800-433-3982

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CMHC Report Cards

- ValueOptions® will generate a monthly report card for services provided to BlueCare and TennCare Select members through the Community Mental Health Centers (CMHCs).
- The goal of the report card is to improve quality of care through improving access to services, improving seven day post-discharge follow-up percentages, reducing delays in service, and reducing readmission rates.

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Basic Report Card Specifications

- CMHC specific report card information will only be shared with that CMHC and VSHP.
- ValueOptions® will establish a baseline for each CMHC provider using claims and encounter data submitted to VSHP for the months of Jan – March 2010.
- A baseline for the State will be created through an aggregate of this data for all CMHCs in the East and West Regions.

Basic Report Card Specifications, cont.

- ValueOptions® will identify the member as a client of the CMHC through the 180 day claims history prior to the review month. If the member has a claim with the CMHC in the preceding six months, then the member will be identified as a client of the CMHC.
- ValueOptions® will produce the report card with at least a 120 day lag to reduce inaccuracies in the claims/encounter data. For example, an April 2010 report card will be produced no earlier than August 2010.

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Report Card Timeframes

- CMHCs can expect to receive their first report cards in late September or early October for Dates of Service (DOS) in the Second Quarter 2010.
- For the first three monthly report cards received, CMHCs should analyze the information provided for accuracy and alert ValueOptions® should they notice any data integrity issues.
- Beginning with the fourth monthly report card, CMHCs that fail to meet standards will be asked to submit a plan of action for correcting deficiencies.

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ValueOptions VSHP Behavioral Health Provider Report Card.doc [Compatibility Mode] - Microsoft Word

ValueOptions VSHP Behavioral Health Provider Report Card

Provider Name:
Month/Year:
Total Unduplicated VSHP Members Served:
Total Unduplicated VSHP Members Served in Case Management:

Element	Definition	Monthly Result	Provider Baseline Result	CMHC Aggregate Result
Case Management Admissions	By CMHC provider with a Case management claim in the month and an admission to inpatient and/or readmission to inpatient in the month.			
Readmission rate	By CMHC provider readmission detail report for the month attach member to provider by the 180 day claim/encounter history of the CMHC on member			
Service Delays	Services scheduled outside of the required timeframe post discharge from acute services.			
Follow-up in 7 days from discharge	From the Discharge date for a member with an acute service, return the Date of Service claim & encounter history of the provider for 1) the HEDIS qualifying encounter and 2) other CMHC encounters (case management). Measure days between discharge date and service date.			
Overall hospital admission rate	1) Provider's total number of unique members served in the month based on claims/encounter in the month and 2) the total number of inpatient admissions for the provider's membership group (claim/encounter in the preceding 180 days) and return the admissions per 1000 rate based on the inpatient admissions in the month.			
Percentage of priority members with a service in the month	Return the % of priority SED/SMPI members with an encounter in the month			
Percentage of members with a secondary provider	Return the % of members with an encounter by more than one provider in the month			

Update On Self-Reports

Update on Self-Reports

- Submission rate has improved across all reports and all regions, but there are several reports that are coming in after the deadline of the 15th.
- Compliance rates improved overall from the 4th quarter 2009 to the 1st quarter 2010 for the delivery of case management services in 0-7 days, but most areas still fall short of the standard. Compliance with Initial Appointment Timeliness standards declined overall from 4th quarter 2009 to 1st quarter 2010, with no elements consistently meeting standards.
- MCRT reports should now be completed on the new form that was distributed by the Bureau of TennCare to the crisis teams around August 13th. 2010, effective for July 2010 data.

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Decisions, Decisions…

- VSHP and ValueOptions will continue to collaborate with the Bureau of TennCare and TAMHO to evaluate the current reporting methodologies.
- The objective is to identify opportunities to capture value-added information from authorization and encounter data whenever possible to reduce or eliminate the need to capture information manually.

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BlueCare/TennCare Select – Quick Reference Guide

Medical Management	
BlueCare UM Prior Authorization Line	1-888-423-0131
TennCare Select UM Prior Authorization Line	1-800-711-4104
UM Authorization Fax Line East	1-800-292-5311
UM Authorization Fax Line West	1-800-919-9213
Case Management Line	1-800-225-8698
Southeastrans – Non-Emergency Transportation	
Statewide	1-866-473-7565
Operations	
Member Service Line	1-800-263-5479
Provider Service Line	1-800-276-1978
VO National Service Line (for credentialing and contracting inquiries)	1- 800-397-1630
Nurseline – 24/7	1-800-262-2873
Provider Initiated Notice Fax	
TennCare Select Statewide	1-800-859-2922
BlueCare East Region	1-800-859-2922
BlueCare West Region	1-800-320-3800
Website	www.vshptn.com
TDMHDD Mental Health Crisis Information Line	**1-800 809-9957**

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New as of August 2010

Questions?

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