HCCA
P14 Discover How Managed Care Plans are Responding to their Obligations in Detecting, Investigating and Preventing Fraud and Abuse in the Health Care System

Sunday, March 26, 2017 9AM to 12AM

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AGENDA

- SIU Mission
  - FWA Prevention
  - FWA Identification
  - FWA Investigation
  - Correction
  - Reporting
- Program Integrity/Compliance

SIU MISSION

Report
Correct
Prevent
Identify
Investigate

Fraud, Waste, and Abuse

3/20/2017
FWA PREVENTION

PREVENTION
Education & Training
• Members
• Providers
• Employees

• Training Programs
• Website
• Member/Provider Manuals
• Newsletters
• Anti-Fraud Plan
• OIG Links

PREVENTION
Reporting Mechanisms
• FWA Hotlines
• Ethics & Compliance Hotlines

• Anonymous
• Confidential
• Non-retaliation

Posters
Intranet Site
Badges
Website
**PREVENTION**

- Clearinghouse
- Instructions
- Coding Assist
- Clinical Edits
- Provider Education Letters
- Provider Pre-pay review
- Claim Line Pre-pay Review

**Clinical Edits**

- Clinical editing rules
  - Rebundle
  - Duplicates
  - Modifiers
  - Mutually Exclusive
  - Invalid Coding

- Edits customized per line of business

**Clearinghouse**

- Duplicates
- Patient sex and surgical procedure do not match
- Member mismatch

**Coding Assist**

- Peer Comparison base line
- Send claim back to provider in clearinghouse with notification of aberrancy
- Follow with letter to provider
- Certified coder calls provider
- Monitor for billing behavior change
Claim Line Pre-pay Review

Provider Education Letter

To whom it may concern:

As part of our ongoing process to identify fraud, waste, and abuse in the healthcare system, CareSource may periodically conduct an audit of medical claims data.

During a recent review of medical claims data, a pattern of unbounding ophthalmic exams and refractive services was noted. CareSource policy, which follows CMS guidelines, states that when the refractive service (S2015) is performed during a routine eye exam (e.g., CPT codes 92002; 92004. 90072; 90074); the refraction is considered part of the exam and is not separately reimbursable.

Please reference CareSource Network Notification dated October 26, 2011 regarding the CareSource refraction policy. For your convenience, the notification is included with this letter.

This letter is being sent for educational purposes in the hopes that the areas of concern highlighted will be addressed by your practice.

Peer Comparison Chart
Provider Pre-Pay Review

Billing aberrancy identified by Investigative Team → Minimal dollars/exposure

Send Letter to provider - all claims must be submitted with Medical Records → Records review drives payment decision

Change Behavior

Provider Pre-Pay Modification Letter

[DATE]
[PAYER NAME]
[COVERED NAME]
[COVERED NPI]
[CITY, STATE, ZIP]

Dear Provider,

Please be advised that CareSource has implemented Prepayment Review of your Medicaid claims.

CareSource is mandated by the Centers for Medicare and Medicaid Services to have an effective compliance and detection program that identifies improper, unnecessary, and inappropriate use of Medicaid services and overpayment for services. In addition, in an effort to safeguard the Medicaid program, your state office for Program Integrity requires a continuum of activities to be carried out, including pre-payment review.

Our team will be evaluating various sources of information for risk-related practices. Prepayment reviews look for overutilization of services or other practices that, directly or indirectly, result in unnecessary cost to the health care industry. Examples include but are not limited to: selection of the wrong CPT, ICD-10, HCPCS codes for services rendered, lack of documentation in the medical record to support services billed, billing for items or services that should not or were not provided based on documentation in the medical record. These audits can also be conducted to ensure the claim meets documentation requirements. If any documentation is missing, additional documentation must be provided to support services provided to the member. Based upon the findings of our evaluations, you have been selected for a comprehensive medical review.

Prepayment review of Medicaid claims is not a random audit and is not subject to appeal. Claims for services that do not meet guidelines for reimbursement will be subject to denial.

Prepayment review will be implemented beginning on [DATE] for those claims with dates of service beginning [DATE] that have not yet been paid or submitted. All claims must have the following additional documentation submitted in support of the claim: demographic report, service description, diagnosis, insurance, lab results, and other appropriate documentation. Claims submitted without documentation will be denied.

During the time that you are on Prepayment Review, please be advised that if any claims submitted without the required documentation will be denied. Should additional documentation be requested to support services billed, you will be notified via letter and will have 30 days to submit the additional required documentation. If the required documentation is not received within 30 days of date of notification letter, the entire claim will be denied.

Please ensure all documentation sent to CareSource is in paper format and packaged as a single letter correspondence to the following address:

CareSource
Prepayment Review Team
P.O. Box 2000
Shelby, Ohio 44875-2000

Please do not submit appeals requests until claim has been processed and denied.

If you have any questions about submission of claims, please contact [Name] at [Phone] or via email to [Email]

Sincerely,

CareSource Provider Pre-Pay Team
## PREVENTION

### Federal Laws
- False Claims Act
- Prohibited Affiliations
- Disclosures
- Stark – Physicians Self-Referral
- Anti-kickback
- Civil Monetary Penalties
- Criminal Health Care Fraud Statute

### State Laws
- False Claims Acts
- Fraud Statutes

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## PREVENTION

### Identity Theft

**WHO TO CONTACT**

**FIGHT BACK!**

**Medical Identity Theft & Medicare Fraud**

**DETER**

- **Detect**

**Defend**

**Tips to Avoid Medical ID Theft**

**Detect**

- Watch for unusual bills or charges on your Medicare or health insurance statements.
- If you notice any unusual activity, contact your provider and Medicare.
- Keep your Medicare card and other personal information secure.

**Defend**

- Report any suspicious activity to your Medicare carrier.
- Place a fraud alert on your Medicare card.
- Change your Medicare number and personal information.

**Tips for Patients**

- Keep your Medicare card and other personal information secure.
- Report any unusual activity to your Medicare carrier.
- Change your Medicare number and personal information.

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## PREVENTION

### Fraud Alerts
Creating an Effective Program Integrity Program - Stakeholders

Internal FWA Awareness and Collaboration
- Compliance Department
  - Fraud Investigation Team
  - Financial Management
- Pharmacy
- Risk
- Internal Audit
- Provider Contracting
- Credentialing
- Sanctioned Providers
- Health Care Analytics
- Anti-Fraud Task Force
- Health Plan
  - HP Leadership
  - Gov’t Relations
  - Provider Relations
  - HEDIS
- Clinical Services
  - Appraisals and Reviews
  - Medical Directors
  - Medical Audit
  - Coding and Policing
- Compliance
- Fraud Hotline – Internal and External
- Associate FWA Training
- Provider Contracting
- Credentialing
- Sanctioned Providers
- Health Plan
  - Gov’t Relations
  - Provider Relations
  - HCMS Clinical Services
  - Appeals and Grievances
  - Medical Directors
  - Medical Audit
  - Coding and Policy Changes

External Monitoring and Intelligence Gathering
- MED-MED
  - Case Assessments and Trends
  - Fraud Alerts
  - HEDIS Database
- CMS
  - Health Integrity Referrals
  - Part C & D Work Group
  - Fraud Alerts
- MEDIC
  - HFPP
  - HHS-OIG
  - Referrals
  - Sanctioned List
  - Enforcement Database
  - Fraud Alerts
  - Task Force
  - Statewide
- HEAT Strike Force
  - Enforcement Activity
- FBI
  - Task Force
- Medicaid Audit

Internal Identification Sources
- Compliance
  - Fraud Hotline - Internal and External
  - Associate FWA Training
- Provider Contracting
  - Credentialing
  - Sanctioned Providers
- Health Plan
  - Government Relations
  - Provider Relations
  - Health Care Management Services
Internal Identification Sources

- Pharmacy
- File
- Clinical services
  - Appeals and Grievances
  - Medical Directors
  - Quality of Care Issues
  - Coding and Policy Changes
- Health Care Analytics
  - Cost Containment

Internal Identification Sources

- Special Investigations Unit
  - Anti-Fraud Tools
    - Post-payment Review
    - Pre-payment Review

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FICO® Insurance Fraud Manager

Review medical claim

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Anah

Analysis
LEXIS POST-PAY

DATA ANALYTICS
CASE TRACKING SOFTWARE

External Identification Resources

- NHCAA
  - Latest Schemes and Trends
  - SIRIS Database
  - Training Opportunities

- Health and Human Services - Office of Inspector General
  - Sanctioned List
  - Fraud Alerts
  - Task Force Referrals

External Identification Resources

- State Regulatory Agencies
  - Program Integrity Unit
  - Insurance Fraud Division
  - Medicaid Fraud Control Unit

- CMS
  - MEDIC Fraud Alerts
  - Part C & D Work Group Meetings

- FBI
  - Task Force Meetings
External Identification Resources

Medicare Fraud Strike Force Locations


External Identification Resources

Healthcare Fraud Prevention Partnership

The HFPP began in 2012 and started with approximately 20 Partners.

Today the HFPP has grown to 75 Partners, including federal agencies; private payers; and anti-fraud, waste, and abuse associations.

Healthcare Fraud Prevention Partnership

- Studies & Algorithms
- In-person regional information sharing sessions
- Real-time provider alerts
- Fraud scheme notifications
Healthcare Fraud Prevention Partnership (HFPP)

Current Membership is at 75 Partners

FWA INVESTIGATION

Investigative Process

▶ After a concern or issue is identified, then what?

▶ The investigation begins but...

▶ What are we looking for?
WHERE DO WE START?

- Gather information!
- What kind of information?
- How do we determine if there is a credible allegation or evidence of fraud?

DEFINITION: CREDIBILITY
Merriam Webster Dictionary

1: the quality or power of inspiring belief
2: capacity for belief
3: the quality of being believed or accepted as true, real, or honest
CREDIBLE EVIDENCE
The legal definition

Credible evidence is not evidence which is necessarily true, but is evidence worthy of belief, that is, worthy to be considered by the jury. It is often natural, reasonable and probable as to make it easy to believe.

GATHER PRELIMINARY INFORMATION (1)

- What does that look like?
- Who is involved? Provider/member/vendor.
- What is the specific issue or allegation fraud or abuse?
- What is available that makes you think there is a concern?

GATHER PRELIMINARY INFORMATION (2)

- How much exposure does the Plan have?
- How urgent the situation is? Is there potential member harm?
- Based upon these answers, you may proceed in various ways.
DO YOU HAVE CREDIBLE EVIDENCE TO PROCEED?

- NO. What actions do you take now?
- YES. Proceed with a Comprehensive Investigation.

GATHER COMPREHENSIVE INFORMATION

- Review the provider / member/vendor files
- Pull 3 to 6 years of comprehensive paid and denied claims
- Research the medical necessity, CPT code and the regulation
- Determine if other providers / members are involved
- Interview the person submitting the allegation if possible

GATHER COMPREHENSIVE INFORMATION

- Obtain medical records for analyzing
- Perform a service verification call
- Possible surveillance & onsite visit
- Prior internal complaints or external complaints documented from state of federal agencies,
- Online sources such as the internet, Facebook, LinkedIn, etc.,
Gather Information...

- This investigative stage may also include interviewing relevant parties such as the provider or member, obtaining signed statements from witnesses or the subject of the investigation, and reviewing a sampling of claims data.

- Review internal systems to assure it has been configured correctly (really a preventative step).

Gather Information...

- Any action taken in the investigation stage, whether it is requesting medical records, conducting an interview, completing a telephone call, or requesting claims reports, must be documented in the case files.

Is There Credible Evidence to Proceed?

- NO. What actions do you take now? Let it go...

- YES. Proceed with an evaluation of the facts.
EVALUATING the INFORMATION

- What conclusions may you draw from the information and whether we have a potential FWA case or not?
- Some questions to consider: What does the information and data tell us?
  - Is there a reasonable explanation for the situation or behavior that was suspected as fraudulent or abusive?
  - Would this medical treatment for this diagnosis be consistent with acceptable medical practices?
  - Do you have a statement from an independent clinician to state a contrary position?
  - What is the provider’s explanation?

QUESTIONS TO CONSIDER…

- Do we have any admission of guilt by the member or provider?
- Do we have signed statements from relevant parties, i.e., from a member, to state that the member never received the service billed?
- Is this information reliable?
- Do other factors come into play, e.g., has the member ever been diagnosed with dementia?
- Does the claim data support the allegation of inappropriate billing?
- Do you have enough information to make a decision? If so, what is the decision and what are your next steps? If not, what other information would be helpful to make a decision? Is the information available?

REAL LIFE STORIES

Provider A

Optical
- Exposure: $250,000
- Scheme: unlawfully used various providers NPI / EIN to create contracts with various MCO’s in NYC and they also used the provider’s information to open bank accounts / furnish the office with the best equipment available. With the help of a billing agency they managed to obtain member information to falsify medical records / claims. In this case, we were unable to directly recovery the funds as the provider was indicted.
- Civil law suit.
REAL LIFE STORIES
Provider B

Pain Management

- Exposure: Significant Member Harm
- Scheme: Provider refused to bill health plan, required members to pay $150 or $200 cash per "office visit." The only service was to write a RX for controlled substances (suboxone, methadone). An E/M visit for substance use is a Medicaid covered service; member billing is prohibited.
- Initial overpayment recovery is to make the members whole.
- This case is still open pending responses from NY Office of Medicaid Inspector General (OMIG) and NY Office of Professional Medical Conduct (OPMC), Drug Enforcement Agency (DEA).

REAL LIFE STORIES
Providers C and D

Examples

- Mama bought me a CT Scanner -
- 6.5 Years in prison
- Tiptoeing through the portal

INVESTIGATE

Case Tracking Software

Compliance Committee
Board Audit and Compliance Committee
- Identify Risks
- Report Actions

Investigation Committee
- Present evidence or impact
- Appropriate action or require more information

Investigation
- Review Triage findings
- Report FWA to appropriate agencies
- Investigative plan
- Background checks
- Data analytics
- Interviews
- Social Media
- Medical record SVRS request
- Medical/Coding experts
- Medical records
- Legal
- Law Enforcement/State Agency Collaboration
- Recommend Corrective Actions to Investigation Committee
- Compliance Committee - Board Audit and Compliance Committee
- Identify Risks
- Report Actions
CORRECTION

Correct!
Provider
Ed & Training
RECOVERY
Legal Action
Suspension
Contract Terminated
Correct for whom?
- Plan - Do we help or hurt?
- Providers - Primary Concentration
- Members - What are State or Federal guidance?
- Employees - Collaboration with HR
- Vendors - Collaboration with Contracting / Other Operational Areas
Plan Issues

► Is your claims processing system configuration appropriate?

► What has the Plan done to contribute to potential issues?

Provider Training & Education

► Arrange for specific training of the provider and office staff for the identified issue.
► If you are seeing trends, offer periodic coding classes, or newsletters, or faxblast to all offices

When:
► If it appears to be a lack of understanding
► If this has not been a recurring theme with this provider's claims

Provider on Review

For the claims in question, consider:
► Require authorizations for all services in question, or
► Review claims prior to the release, or
► Request medical records for all cases.

When:
► The issue keeps appearing and perhaps training and education did not make a difference.
Provider Limitations

- Close Providers Panel to New Membership
- Limit availability of Provider to members.

When:
- You are working with provider to resolve issues.
- You feel it is somewhere between errors and perhaps abusive practices.

Provider Overpayment Recovery

Consider: What claims will be processed, paid, and denied going forward? What action is needed to address past claims. Actions will vary.
- Request a refund on claims/issues in question
- Withhold the payment of future claims to recover overpayments
- Negotiate a settlement amount

When:
You reach a conclusion that the claims were paid incorrectly and/or should not be paid going forward.

Provider Auditing

"Auditing is a formal, systematic and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited, and normally performed by individuals with one of several acknowledged certifications. Objectivity in governance reporting is the benefit of independence."

Provider Monitoring

“Monitoring is an on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process.”


Provider CAP

- Establish a formal Corrective Action Plan (CAP) (see template) for the Provider to include:
  - What the issue was
  - Who is the responsible party
  - What is going to be done to rectify it
  - By what date
  - Consequences if fail to implement
  - Validate

When:
- Multiple findings
- Dollar Threshold is “$$”

Provider CIA

- Establish a “Compliance” Integrity Agreement with the Provider (similar to a Corporate Integrity Agreement issued by the DOJ)

When:
- Significant, multiple findings
- Dollar threshold is “$$$$”
- Termination may not be an option
- The provider is willing to work with you
Other Provider Sanctions

- Law Enforcement
- Termination
- Legal Action
  - Civil or Criminal
- Reporting to External Agencies

Other Provider Sanctions...

When:
- Provider is not willing to work with you.
- You have run out of other options.

Employee Considerations

Work with Human Resources but consider...

- Confidentiality
- Experience in Investigations
- Disciplinary Actions
- Terminations, if needed
Member Considerations

Is it the Health Plan’s obligation to investigate and take corrective action against members?
- No!
- Prepare Documentation
- Distribute to State or Federal Regulatory Agencies
- Share with Commercial Insurance Policyholders

Vendor Considerations

Who is managing vendors / FDRs?
- Contractual obligations
- Validation Processes
- Variance Reports
- Oversight at an Enterprise Level

REPORTING
Open Discussion and Questions
Contact Information

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