

Compliance, Medicaid Integrity, & Service Verification

Providing Community Mental Health and
Substance Abuse Services in the Era of
Healthcare Reform

Community Mental Health Partnership
of Southeast Michigan Staff Training

What This Training Will Cover

- An explanation of what is Compliance and Medicaid Integrity
- Laws related to Compliance and Medicaid Integrity
- What is Considered Medicaid Fraud, Abuse, and Waste
- Providers'/Staffs' Role & Responsibility in Preventing Fraud Abuse and Waste



Health Information Portability and Accountability Act (HIPAA)

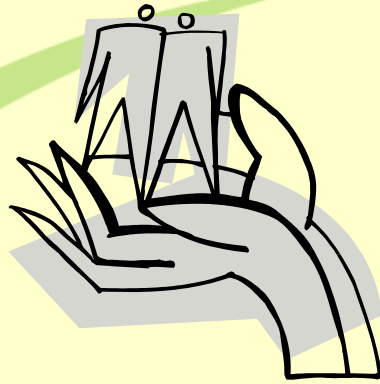
Federal Protections for Health Care
Information

HITECH Additions with Health Care Reform



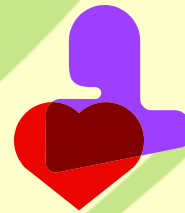
Health Information Portability and Accountability Act (HIPAA)

- Federal law to ensure all states are providing same protections with people's Protected Health Information (PHI) in healthcare
- Has specific requirements for privacy (how information is shared, what can be shared without consent, what requires consent, need to provide Notice of Privacy Practices)
- Requires a "need to know"
- Has specific security requirements for protecting how health information is exchanged electronically
- Protections are in addition to already-existing laws (like the Michigan Mental Health Code & 42CFR Part 2 for substance abuse)
- *Confidentiality/HIPAA is more thoroughly covered in your Recipient Rights Training*



Balanced Budget Act (BBA)

Improving Quality of Health Care for
People with Medicaid



Balanced Budget Act (BBA)

Showed greater care for the quality of healthcare services that people with Medicaid receive, including:

- Having to show how authorizations for services are decided; having a utilization management program
- Measuring the quality of services people get
- Providing specific Customer Service functions and giving people more information about their care & the system
- Giving people the right to file a grievance if they are not satisfied with the quality of their services
- Giving people the right to appeal a decision about their services
- Requiring all states are audited by an external auditor for their compliance with the BBA



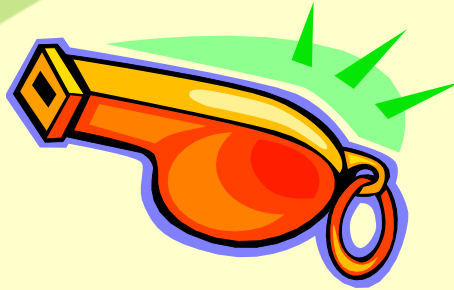
**Federal False Claims Act
and
Michigan's False Claims Act
The Origins of Preventing
Fraud**



Federal False Claims Act

The False Claims Act applies when a company or person:

- **Knowingly presents (or causes to be presented) a false or fraudulent claim for payment,**
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid,
- Conspires with others to get a false or fraudulent claim paid,
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.



Whistleblowers' Protection Act

Protections for Employees Who
Make Valid Reports of Fraud or
Abuse

Whistleblowers' Protection Act

- **Provides protection to employees who report a violation or suspected violation of state, local, or federal law**
- Protects employees who participate in hearing, investigations, legislative inquiries, or court actions
- Prescribes remedies and penalties



Anti-Kickback Law

Preventions for Benefiting from
Biased Referrals

Anti-Kickback Law

- Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration (fee) to induce (persuade) or reward referrals of items or services reimbursable by a Federal health care program.
- “Remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Makes it illegal to make referrals to agencies or providers and get some benefit/something of value for those referrals from that agency/provider.
- It’s illegal whether one either asked for a kickback or the provider offered a kickback.
- Both parties are criminally liable when there is an impermissible “kickback” transaction.

The law prevents any Medicaid provider from getting some type of gain in controlling/limiting the choices people have about where they can get services

Examples of Illegal Kickbacks

- Buying or selling referrals; trying to get referrals and offering something in return
- **Waiving copays/deductibles in ways not allowed by Medicaid/Medicare in order to get referrals or gain some benefit for your business (can also be considered a fraud/abuse related overpayment depending on how the arrangement is sought/made)**
- Freebies, discounts, or money being paid between 2 healthcare providers
- Includes getting trips/gifts/meals from other providers or pharmaceutical companies



Deficit Reduction Act of 2005

Increasing Efforts to find
Fraud/Abuse and Recoup Medicare
and Medicaid Dollars

Compliance & Medicaid Integrity

In the recent past, there has been an increased focus on how Medicaid and Medicare monies are spent – essentially how government tax dollars are being spent on these programs.

Federal law has been developing ways those monies can be taken back if certain requirements aren't met, in order to help balance the federal budget.

So if Medicare/Medicaid programs or providers can't show they meet those requirements, they have to return those funds plus pay fines. Medicare was first to be reviewed, followed by Medicaid

“The only reasonable conclusion is that after years of significant and impressive funding for enforcement efforts directed toward Medicare compliance, the tide has turned and (to the delight of many at the federal level) it is now Medicaid’s turn.”

Issue Brief, New Medicaid Compliance Issues from the Deficit Reduction Act
National Council for Community Behavioral Healthcare
Mary Thornton, BSRN, MBA

The Deficit Reduction Act, 2005

Has Incentives for States to Create their own False Claims Acts to prevent misuse of Medicaid monies

Three important points of False Claims Acts:

- 1. Civil prosecutions do not require proof of fraud, but only proof that provider acted in “reckless disregard” or “deliberate ignorance.” No “ostrich defense.”**
2. Qui tam, or “whistleblower” provisions that allow private citizens to bring suit against providers and collect a portion of monies recovered.
3. Very high penalties assessed on a per claim basis for violators. As much as \$11,000 per claim!

Deficit Reduction Act (DRA) 2005

- A number of states already have a False Claims Act, **including Michigan.**
- A State False Claims Act law
- Under the Deficit Reduction Act (DRA), **states that have false claims laws that are as tough as the federal law get to keep an additional 10% of recoveries. This is in addition to state share of payments!** (so having a state law allows state to keep some of the Medicaid money that is taken back in audits)

Stiff Penalties for Non-Compliance with the DRA

- Federal penalties include up to 5 years in prison with \$250,000 fine for an individual or \$500,000 for an organization
- Civil penalties of up to \$10,000 per claim
- Exclusion as a provider for a minimum of 5 years

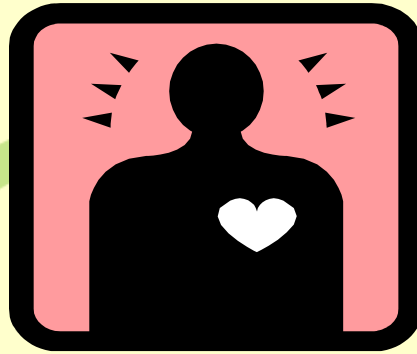
Community Mental Health Partnership of Southeast MI Compliance Program

The CMHPSM Compliance Program is both a specific oversight role of the CMHPSM Compliance Committee and a collaboration amongst Compliance, Finance, Utilization Management, Provider Network, Quality, and Recipient Rights across the region and at the PIHP to ensure the following activities occur:

- ❖ Training/education efforts with staff and contractors with curriculum driven by HIPAA, DRA and Health Care Reform requirements
- ❖ Updating employee handbook to include information
- ❖ Updating Compliance Plan and related Policies & Procedures to assure they are current

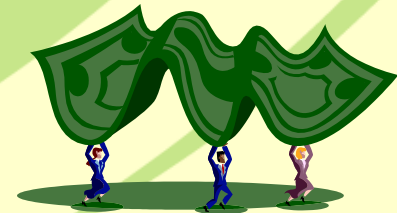
Community Mental Health Partnership of Southeast MI Compliance Program (Con't)

- ❖ Monitoring providers at least annually including a review of potential fraud/abuse/waste
- ❖ Addressing “at-risk” providers not fully compliant with their requirements; recommending sanctions/ board action of providers not meeting contract requirements
- ❖ Monitoring Medicaid service verification of providers
- ❖ Ensuring suspected and confirmed cases are reported to state/federal authorities (i.e. OIG)
- ❖ Conducting internal investigations of suspected fraud/abuse



Patient Protection & Affordable Care Act of 2010

HealthCare & Education Reconciliation Act of 2010



Changes Brought By Healthcare Reform Laws in 2010

- Healthcare Reform Laws of 2010 have new increased requirements for accountability and transparency in how Medicaid \$ is spent, based on concerns for misspending federal funds, fraud, abuse, waste *and whether monies were used as intended and get the desired affect*

Those concerns resulted in:

- New reporting requirements/protections
- Expanded definition of Fraud/Abuse/Waste

Fraud, Abuse, and Waste

Fraud = Intentional deception

Abuse = Non-compliance with or errors in maintaining standards

Waste = Inappropriate utilization and/or inefficient use of resources

- Medically unlikely services
- Clinically unlikely services



Expanded Definition of Fraud/Abuse

“ Failure to comply with any professional standards for health care, standards for medical necessity, or standards for billing/business operations”

Anything that could result in potential false claims. **Includes a broader definition of an “overpayment” of Medicaid funds...**

“Overpayment” Considered Fraud/Abuse

Anytime a provider submits a bill/claim and gets paid for that claim...
if they can't show the all correct documentation that they provided the service specifically the way it's supposed to be provided, THEN
the federal government considers that provider was paid for a service they cannot prove they did, was therefore **“overpaid”**, and expects the provider to pay that money back.

Overpayments are also called a “Reverse False Claim”

Overpayment Examples That Could Be Fraud/Abuse - Billing

- Inaccurate billing; Billing or record-keeping errors
- “Up-coding” - Billing for higher level of service than provided
- Billing for more time than the service was provided
- **Submitting a claim too late**
- The service is not billable – **wrong code**, doesn't meet the definition of the service, or service not in biller's contract
- Billing for services not provided at all, or not provided face-to-face
- Reckless disregard of “truth/falsity” – errors by not checking/verifying what you submit
- Billing a Medicaid beneficiary for Medicaid covered services
- Creating waivers with copay/deductibles to benefit of biller

Overpayment Examples That Could Be Seen as Fraud/Abuse – Provider Qualifications

- If an individual or agency's licensed has lapsed and they continue to bill
- **A mid-level practitioner who needs to be supervised and the supervision doesn't occur the way it should, the practitioner is then exceeding their scope of practice and shouldn't bill**
- **Practitioner not meeting licensing, certification, or training requirements to provide certain services**
- Being in business/having a contract with a provider or individual (including CMH or provider staff) who've been excluded as a Medicaid provider by the state or the federal government. Includes accepting billings and paying claims or salaries to them.

Overpayment Examples That Could Be Fraud/Abuse – Plan of Service/Treatment Planning

- No current treatment plan or individual plan of service (IPOS)
- **Documentation is illegible**
- **Missing signatures where signatures required**
- Content of treatment plan/IPOS is vague
- Treatment plan/IPOS is not completed and signed by deadlines (including if needs physician/ psychiatrist signature)
- There's a mismatch between the services in the IPOS/treatment plan and the services provided (including if the treatment needs change) but the IPOS/treatment plan doesn't reflect that change
- **Same goals for years without progress/questionable need**

Overpayment Examples That Could Be Fraud/Abuse - Documentation

- Mis-documentation (i.e. wrong date, wrong person, doesn't clearly define the service)
- Missing documentation
- Documentation is illegible
- Missing signatures where signatures required
- Missing start or stop time in the note (when required) or amount of time spent providing service
- No progress note for service billed
- The service is not billable – doesn't meet the definition of the service, or that service is not in the biller's contract

Overpayment Examples That Could Be Fraud/Abuse – Service Verification

- There's a mismatch between the services in the IPOS/treatment plan and the services provided
- Not being able to show medical necessity (documentation)
- **Billing for services without documented proof the services were provided exactly as they were billed/paid (date, time, practitioner providing it, etc.)**
- **Not providing a service the way it's defined**
- Making UM/UR decisions that are not well documented or do not follow state/federal standards

“Overpayments” Examples Now Considered Fraud/Abuse – Staff Reimbursement



- Getting reimbursed for mileage or other work-related expenses that is not related to/allowable for your job function
- Falsifying accepted work-related expenses and getting reimbursed for them
- Getting paid for hours you didn't work
- Getting reimbursed for work someone else did
- Billing for services under a different practitioner who is be reimbursed at a higher rate (individual practitioners/clinics)
- Billing a different code to get paid a higher rate (individual practitioners/clinics)

What You Can Do to Prevent Fraud/Abuse/Waste

- All staff, contractors, board members have an obligation not to engage in any fraudulent acts
- **All staff, contractors, board members have an obligation to report any suspected “fraud, abuse or waste” of Medicaid/Medicare**
- Make sure you understand what compliance is and your role in upholding it
- Make sure you are not participating in activities that could look like fraud
- If you are asked to do anything that may look like fraud, report it
- Ensure you are practicing in the scope of your license, certification, training, job function
- Do not accept improper reimbursements (for services, mileage, salary, kickbacks)

What You Can Do to Prevent Fraud/Abuse/Waste

- **Complete all documentation as required (by policy, state, or federal requirements)**
- Write IPOS and treatment plans as required. Keep them up-to-date with clear goals, amount, scope, and duration
- **Ensure the service is being provided the way it is required**
- **Report any suspicion of fraud, abuse or waste** to your local Compliance CMH Liaison the CMHPSM Compliance Officer OR
- Report any suspicion of fraud, abuse or waste to your state or federal reporting contact
- Contact your local Compliance Officer or the CMHPSM Compliance Officer with any questions you may have

If You Are Providing Service(s)

- **Make sure you have a copy of the current IPOS/treatment plan (& any other plans if applicable)**
- Make sure all staff providing the service(s) in the plan have all the training requirements/provider qualifications and are adequately trained on the IPOS/treatment plan
- **Make sure you/staff provide the service(s) as written in the plan(s). If it's not clear, ask for it to be clear**
- Make sure you/staff know how those services are to be provided to the individuals you serve and how they relate to the individual's goals

If You Are Providing Service(s)

- **Clearly document the services you provide and how they are related to the consumer's goals; ALL claims must have documentation to verify the service/back up the claim, regardless of the provider arrangement (contracted provider, LIP, other provider agreements, self determination/choice voucher agreements).**
- Know the definition of the services in your contract

Affiliation Compliance Officers

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Federal and State Fraud Reporting Information

Federal Reporting (Office of Inspector General)

1-800-436-6184 or online

<https://oig.hhsc.state.tx.us/chiefcounsel/tpr.aspx>

State Reporting (Michigan Medicaid Integrity Program)

1-866-428-0005 or Online:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220188--,00.html

Where to Go For More Information

Medicaid Integrity Information:

https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx

<http://www.cms.gov/MedicaidIntegrityProgram/>

<http://www.whistleblowerlaws.com/>

HIPAA and HITECH Information:

<http://hipaasurvivalguide.com/>

<http://www.cms.gov/HIPAAGenInfo/>

CMHPSM Policies & Procedures:

<https://cmhpsmorg-public.sharepoint.com/policies>

Relevant Sites/Information All Providers Need To Know

Medicaid Provider Manual – defines Medicaid covered services* and medical necessity*. Updated quarterly so check it January April, July, October. Key Sections to know: General Information for Providers, Adults Benefits Waiver (if you serve people w/ABW), Mental Health/Substance Abuse*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

Affiliation Policies - policies you are held to by contract with the WCHO or a CMH in our affiliation <https://cmhpsmorg-public.sharepoint.com/policies>

Sanctioned Providers Search – providers sanctioned by federal or state

<https://www.epls.gov/> (Excluded Parties List System – federal)

<http://oig.hhs.gov/exclusions/index.asp> (Office of Inspector General Exclusion List – federal)

http://michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-16459--_00.html (MI state list of sanctioned providers/individuals)