GUIDANCE FOR AVOIDING FRAUD, WASTE, AND ABUSE:

A PRESENTATION FOR NEW JERSEY INTENSIVE IN-COMMUNITY PROVIDERS

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

January 19, 2023

Welcome to the presentation. We will begin momentarily.

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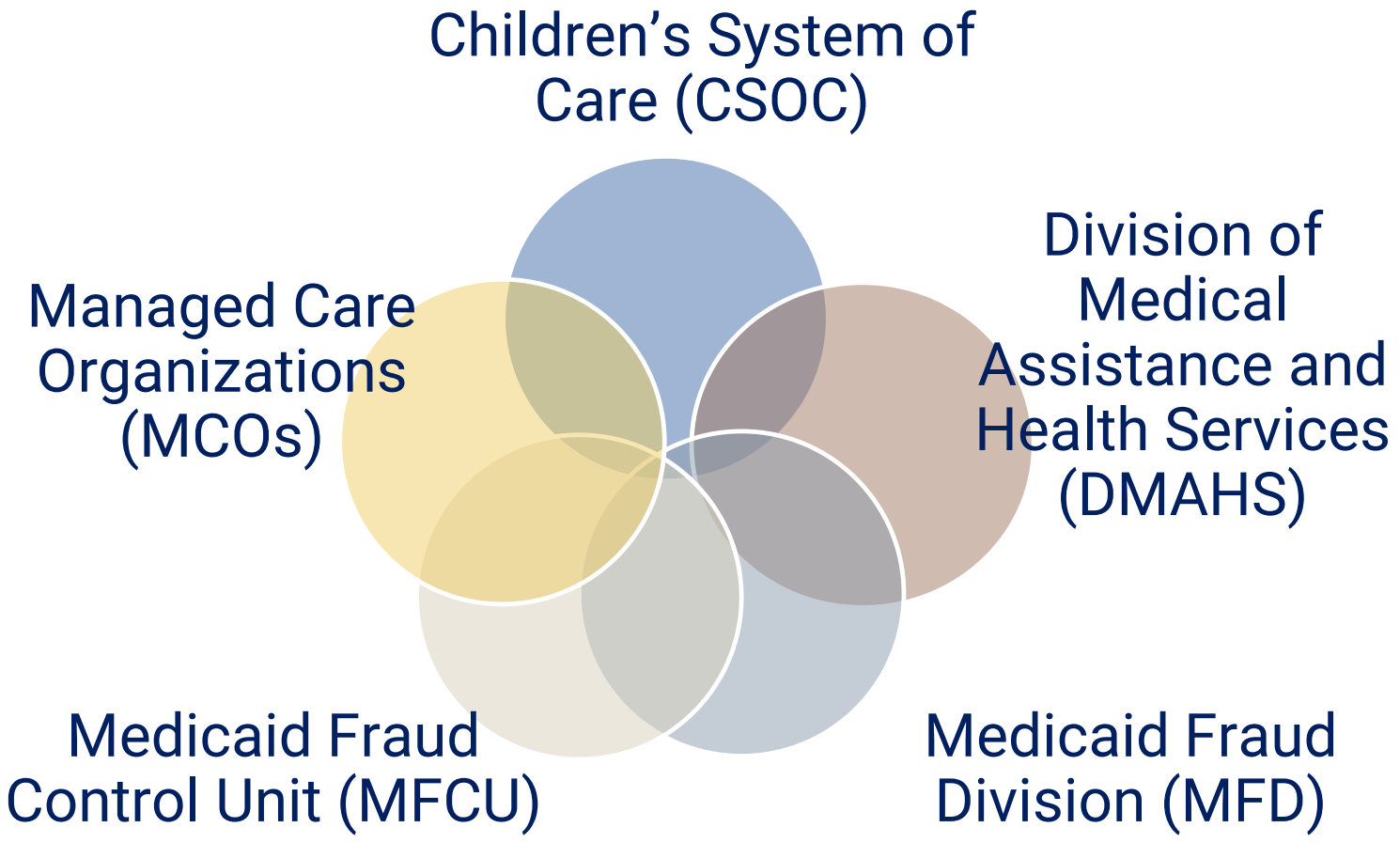
PRESENTED IN PARTNERSHIP BY:



BEFORE WE BEGIN…

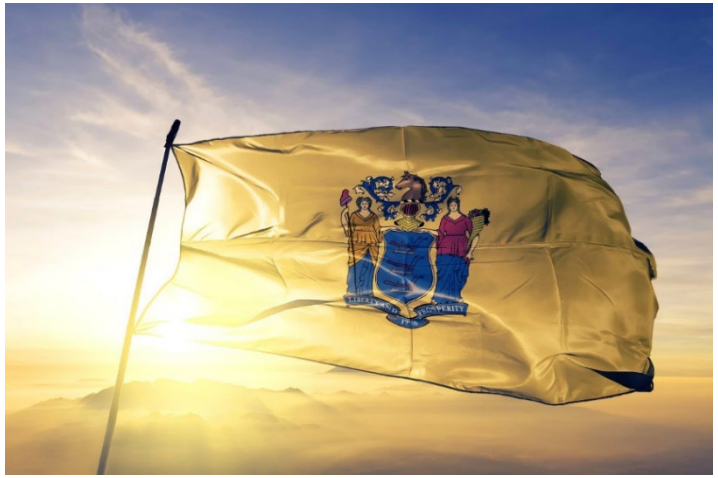
THANK YOU

for participating in the

NJ FamilyCare program!

DISCLAIMER

- This presentation is intended for general educational purposes only.
- It does not replace your responsibility to seek professional guidance, observe all laws and regulations that pertain to your practice as a Medicaid provider and exercise sound, independent, professional judgment.



MEDICAID (NJ FAMILYCARE)

- Throughout this presentation the words Medicaid and NJ FamilyCare may be used interchangeably.

- NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion, with services provided through the State and the five Medicaid Managed Care Organizations (MCOs).

GOALS FOR TODAY: TO HELP YOU BETTER UNDERSTAND

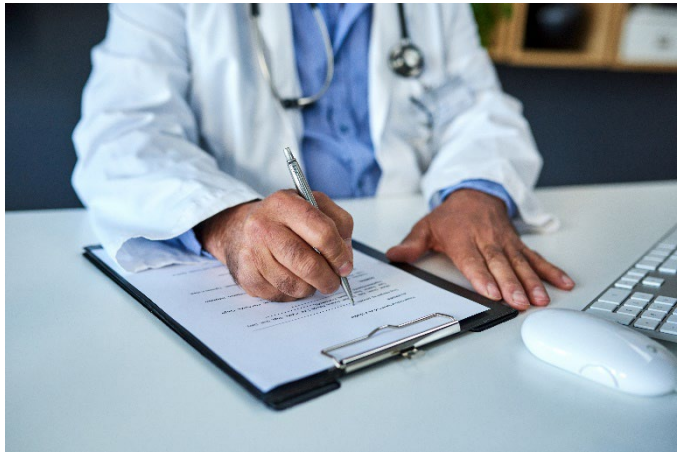
- Intensive In-Community provider's responsibilities for Medicaid compliance
- The Medicaid regulatory framework and program integrity oversight
- Medicaid documentation requirements for payment
- Provider obligation to avoid fraud, waste or abuse of Medicaid funds
- Consequences for non-compliance

QUESTIONS?

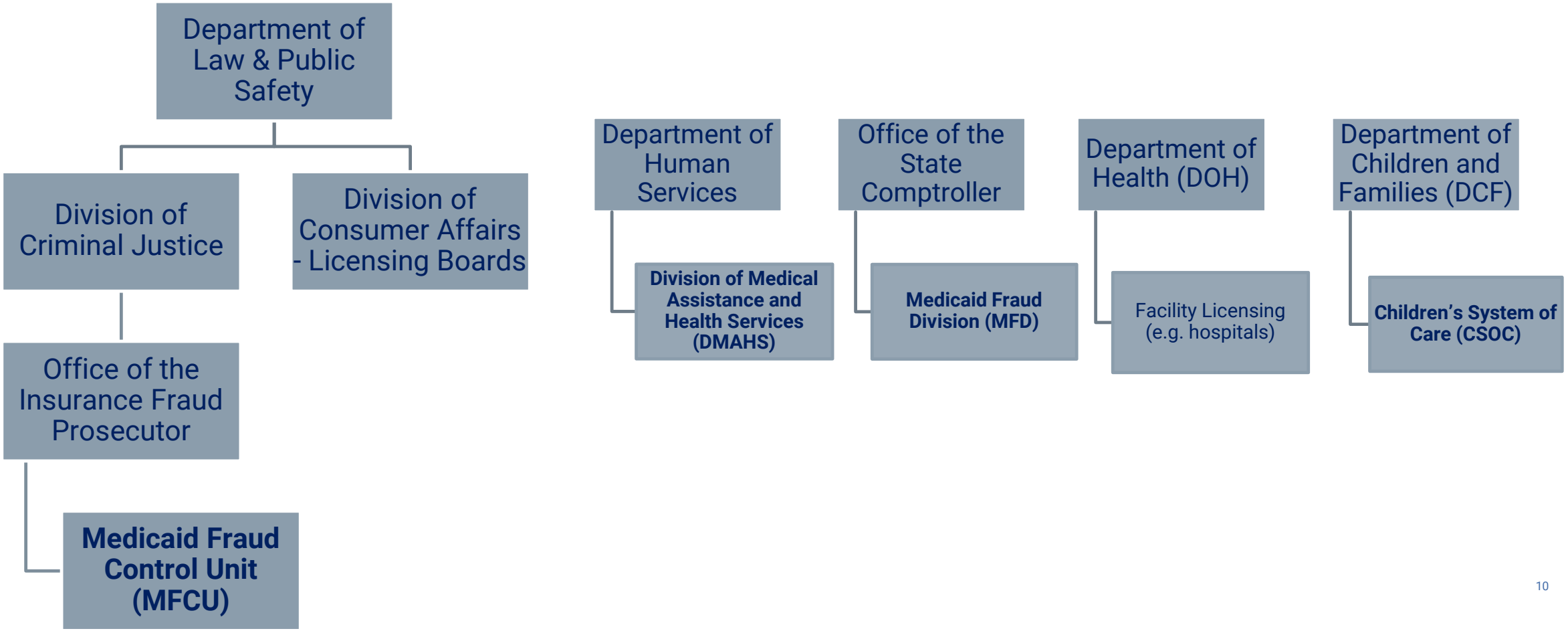
If you have questions throughout the presentation please put them in the Q & A.

WHAT IS MEDICAID?

- Medicaid is a joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals.
- Medicaid participation is voluntary. If you want to participate, you must know, accept and abide by the rules and regulations. Your continued participation requires compliance with the regulatory requirements.



NEW JERSEY AGENCY ADMINISTRATION AND MEDICAID OVERSIGHT



Department of Children and Families (DCF)

What is the Children's System of Care?

- NJ's public behavioral health system that serves youth under age 21 with emotional and mental health care needs, substance use challenges, and/or intellectual/developmental disabilities (IDD).

- The Children's System of Care (CSOC) structure and foundational values ensure that supports and services provided are based on the needs of the youth and family, family-centered, culturally competent and community-based.

System of Care Values and Principles

Youth Guided & Family Driven
Community Based
Culturally/Linguistically Competent

Strength Based	Family Involvement	Individualized
Unconditional Care	Collaborative	Home, School & Community Based
Promoting Independence	Cost Effective	Team Based
	Comprehensive	

Who We Serve

- CSOC services are available to all NJ children and their families. There is no income criteria.
- Over 58,000 youth and families were served in 2021.
- During the month of October 2022:
  - 37,329 children and youth open with CSOC
- Point in Time Data as of October 1, 2022:
  - 16,396 children and youth receiving Care Management Organization (CMO) services
  - 13,182 youth with IDD Eligibility
- 35% of youth accessing CSOC are uninsured, underinsured, or have private insurance that does not cover the costs of CSOC services; 65% have Medicaid coverage.

CSOC Core Components

- Contracted Services Administrator – PerformCare, single point of access, medical necessity determinations, prior authorization
- Claims paid through the state's Medicaid fiscal agent
- Care Management Organizations – Implements a Wraparound service model for youth and families with moderate to high needs
- Single Assessment – Child Assessment of Needs and Strengths (CANS) Tool
- Emphasis on Crisis De-escalation – Mobile Response and Stabilization Services available 24/7
- Family Service Organizations – peer support and advocacy for families & youth
- In-Home and Out-of-Home Treatment Services
- Workforce Training, Certification, and Technical Assistance

Intensive In Community (IIC) – Structure and Vision

- Medicaid State Plan Amendment – Rehabilitation Option
- Medicaid Regulations
- Medicaid Fee For Service Reimbursement
- Program Model
- CSOC Clinical Criteria - Clinical criteria | PerformCare (performcarenj.org)
- DCF Guidance

IIC Service Delivery - Roles and Responsibilities

- Application of CSOC Values and Principles
- Engagement of youth and family
- Assessment and Planning
- Education of youth and family
- Skill Building
- Preparing youth and family for transition to community based supports
- Communication with System Partners
- CFT Participation
- CIACC participation / Community Resource Knowledge
- Practicing within Professional Scope

Licensing Board Sites for Reference

- NJ State Board of Social Work Examiners
  - https://www.njconsumeraffairs.gov/sw/Pages/default.aspx
  - SocialWork@dca.njoag.gov
- NJ State Board of Marriage and Family Therapy Examiners
  - https://www.njconsumeraffairs.gov/mft/Pages/default.aspx
  - MFTinquiries@dca.njoag.gov
- NJ Professional Counselor Examiners Committee
  - https://www.njconsumeraffairs.gov/pc/Pages/default.aspx
  - DCA_Professional_Counselors_No_Reply@dca.njoag.gov

IIC Service Delivery – IIC Practice Reminders

- IIC Credentials and Training:
  - Clinical Level – Independent License Required
  - Professional Level
  - Master's Degree
  - Independent Clinically Licensed Professional Supervising
  - Documented supervision plan
  - Working towards independent licensure
- Caregiver must be included in the work – family systems approach
- IIC Orientation Required

IIC Service Delivery – BA Practice Reminders

- Behavioral Assistance Plan Implementation
- BA Staffing Requirements and Certification
  - Required Training Courses
  - On-line Review
  - Core Competency Verification
- Social Emotional Learning Certification
- BA Certification Website: https://ubhcwebexternal.ubhc.rutgers.edu/ba/mainlogon.aspx
- BA Training Certification - What You Need To Know and FAQs http://www.state.nj.us/dcf/providers/csc/index.html - NJ CSOC TTA Catalog also: NJ CSOC TTA Catalog (instructure.com)

IIC Service Delivery – BPS

- Required Credentials
- Referrals
- Timeframes
- SNA Annual Certification
- Authorization
- Agency Quality Oversight

BPS Reminders and best practices may be found at:

https://www.performcarenj.org/pdf/provider/bps-assessments-instructional-guide.pdf

IIC Service Delivery – BPS

- Independent Clinical licensure (such as LCSW, LPC, or LMFT) is required to complete the Biopsychosocial (BPS) assessment (Service code: H0018TJU1).
- It is not acceptable for the assessment to be completed by a clinical intern or clinicians with an affiliate license under the supervision of an independent clinically licensed provider.
- The BPS Template in CYBER must be completed by the clinician who delivered the BPS service.
- BPS assessors must be certified in the Strengths and Needs Assessment tool in order to provide the BPS service: www.pfccertification.org
  - Annual recertification is required

IIC Service Delivery - BPS

- BPS Assessors must schedule appointment within 3 business days of authorization start date.
- If provider is unable to deliver the assessment, they must notify PerformCare through Member Services or the Service Desk within 3 business days of the authorization start date.
- Completed assessment must be submitted in CYBER within 10 business days of authorization start date and should be submitted prior to billing.
- Submitted BPS Assessments are reviewed by PerformCare within 5 business days.
- If BPS is returned in need of additional information, assessor should provide additional information as requested and resubmit as soon as possible and within 5 business days.

Documentation Requirements

- All Documentation for service delivery for both IIC and BA's is required to be entered into CYBER.
- Individualized Service Plan
- Progress notes
- Diagnosis
- Biopsychosocial if applicable
- Entered by staff delivering the service
- Staff Documentation

CYBER Benefits and Functionality

- Shared Information
- Treatment Plan
- BPS Assessment
- Progress Notes
- Welcome Page
- Authorization Information - Eligibility Information
- Hierarchy
- Reports
- Provider Details

IIC Service Delivery – Administrative Requirements

- Coordination with Referral Sources
  - Memorandum of Understanding
  - Universal Referral Form
  - Frequent and Timely communication
  - Child and Family Team Participation
- Change of Staff Form and managing staff credentials and required documentation
- Update Provider Details Screen
- BPS Referral Capacity Management
- Authorization and Eligibility Verification
- Quality Assurance
- Unusual Incident Reports

Billing Guidelines

- Medicaid offers standard provider training on how to claim
- Performcare Billing Training – BPS Non-Medicaid Eligible Youth
  - https://www.performcarenj.org/pdf/provider/training/billing-claims/intensive-in-community-billing-guide.pdf
- Service Delivery Encounter Documentation forms
  - Signed by Caregiver
  - Must be kept on file to support billing – https://www.nj.gov/dcf/providers/csc/
- Billing Codes
  - Must match credential of staff

IIC Provider Enrollment and Staffing Changes

New Provider Applications – Open Enrollment

- https://www.nj.gov/dcf/providers/csc/iicproviderapplication.html

Change of Staff Forms (located on website)

- Must be submitted along with supporting documents to: IICprovider.communications@dcf.nj.gov
- CSOC approval required prior to hiring new staff

IIC Provider Orientation Resources

- https://www.performcarenj.org/provider/iicproviders.aspx#clinicalguidelines

DOCUMENTATION, RECORDS RETENTION, AND BILLING PRACTICES

Presented by: Amerigroup NJ

ACCURATELY DOCUMENTING SERVICES

- Documentation should occur at the same time as the services rendered.
- Documentation for billing must occur daily, for each day you provide service(s).
- It is the provider's responsibility to know and comply with documentation requirements.

MEDICAID DOCUMENTATION REQUIREMENTS

Providers shall agree to the following:

- To keep such records necessary to fully disclose the extent of services provided, and to retain individual records for the greatest length of time that applies from the date the service was rendered.
- To timely furnish information about such services as requested by regulatory agencies, including the Medicaid Fraud Division.
- If records do not document the type and extent of services billed, payment adjustments are necessary, including requiring repayment to Medicaid or claim payment denial.

DOCUMENTATION

All records / documentation used to support billing must be individualized, reflect actual services delivered, and include:

- Individual's name
- Date of service/time/duration
- The specific services rendered, such as:
  - Intensive In-Community
    - Individual; Biopsychosocial
  - Behavioral Assistance Program
    - Individual; Inclusive of SEL

DOCUMENTATION

Description of the encounter and notation of unusual occurrences

- Signature of person authoring the note
- Signature of supervisor if required

- Service Delivery Encounter Documentation forms
  - Signed by Caregiver

DOCUMENTATION

Notes Must:

- Align with the service or treatment plan's outcomes and strategies.
- Answer the who, what, when, where and why of service provision.
- Be completed by either the individual providing the service OR an individual responsible for the oversight of the direct service provision.
  - If the note is completed by a staff member not providing the direct service, they should have documentation to support the information contained in the note.
- Reflect progress toward or decline from identified outcomes.
- Comply with IIC requirements as detailed by N.J.A.C 10:77: 4 and 5.

DOCUMENTATION

Notes Must:

- Providers using an electronic health record (EHR) or other electronic system must ensure that all information required in mandatory sections is included and individualized for the recipient and that all underlying documentation can be produced to support services rendered during an audit or investigation.

DOCUMENTATION

Notes Cannot:

- Be completed by a staff person not connected to the service provision
- Be duplicative or generic in nature

DOCUMENTATION

- ✓Records/documentation must accurately reflect the services that were rendered.
- ✓Documentation should occur at the same time as services rendered.
- ✓Medicaid will not pay for undocumented or improperly documented services.

DOCUMENTATION

Don’t shortchange yourself...
If it’s not documented or not documented correctly,
it wasn’t done!

RECORDS RETENTION TIMELINES

- Approved Medicaid/NJ FamilyCare enrolled intensive in-community mental health rehabilitation providers shall retain, in a secure location, and in compliance with all applicable Federal and State laws and regulations, confidential information related to the individuals providing or supervising the provision of services and shall produce the information for the Department of Human Services, Children and Families, or any authorized agents of either Department, in an orderly fashion on demand.

RECORDS RETENTION TIMELINES

Timelines vary depending upon the source:

- N.J.A.C. 10:37-6.77
- Records of adults must be retained 5 years after the last date of service;
- Records of children must be retained 5 years after they reach their 18th birthday.
- Article 7.28.A of the MCO contract: 10 years

Follow the regulation with the greatest length of time that pertains to you!

INSTITUTE RESPONSIBLE BILLING PRACTICES

Billing and Coding

- The use of specific codes by the provider that accurately report the services rendered are required to receive payment for those services.

- The codes that are used on the claim form are on the following slide.

IIC / BA CODES

	Current Codes In NJMMIS (including local codes)	National Codes in RMMIS	Unit/ Frequency	Rate	Service Description
27	H2014--TJ, TJUN, TJUP H0036-TJU1, UNU1, UPU1, TJU2, UNU2, UPU2 TJU3, UNU3, UPU3	H2014--TJ, TJUN, TJUP H0036-TJU1, UNU1, UPU1, TJU2, UNU2, UPU2 TJU3, UNU3, UPU3	1 Unit = 15 Minutes	Varies Per Code	BA/IIC
28	H0018TJU1	H0018TJU1	1 Unit = 1 Hour	$ 159.99	Biopsychosocial Needs Assessment
29	H0018TJU2	H0018TJU2	1 Unit = 1 Hour	$ 85.00	Biopsychosocial Needs Assessment
30	H2033	H2033	1 Unit = 15 Minutes	Contracted	Multi-System Therapy for Juveniles (MST)
31	H2019	H2019	1 Unit = 15 Minutes	Contracted	Family Functional Therapy Services (FFT)
74	T203822HA	T203822HA	1 Unit = 15 Minutes	$ 9.75	Transitioning Youth Life Skill Building
75	T2038HA	T2038HA	1 Unit = 15 Minutes	$ 9.75	Youth Support and Training

RESPONSIBLE BILLING PRACTICES

- It is the **Provider's** responsibility to ensure that claims submitted for payment reflect:
  - ✓ the actual service that was provided;
  - ✓ who performed the service,
  - ✓ the location of the service;
  - ✓ the billing entity; and
  - ✓ the time duration for claims that are time-based

- It is incumbent upon **Providers** to be knowledgeable regarding the codes that are used to reflect the services rendered.

IDENTIFY AND CORRECT ERRORS

- Implement a robust system of quality assurance and oversight that reviews compliance on an ongoing basis and adjusts service delivery to maintain outlined standards.

- Supplemental documentation to a note can be added if necessary, as long as the date of the addition is included as well as the initials of the person supplementing the record.

GUIDING REGULATIONS, NEWSLETTERS, BACKGROUND CHECKS, AND THE PUBLIC HEALTH EMERGENCY

Presented by: The Division of Medical Assistance & Health Services

GUIDING REGULATIONS: N.J.A.C. 10:77 4-5

- As IIC providers, it is your responsibility to observe these regulations
- Regulations dictate:
  - Who can provide services
  - Who can receive services
  - Limits on services
  - Allowable vs. non-allowable services
  - Documentation requirements
  - Frequency guidelines
  - Billing codes (codes and rate information can be found here: www.njmmis.com / provider hotline 800-776-6334)

NEWSLETTERS

- Newsletters are used to introduce new programs or services, pending regulatory updates or general program guidance.
- Newsletters can be found on www.njmmis.com.
- Newsletters are searchable by provider type and subject.

NEWSLETTER UPDATE

- Newsletter Vol. 32, No.24 was released 9/14/22 to notify NJ Medicaid/NJ FamilyCare Home Care/CSOC BA/IIC providers of updates and clarifications related to background checks and driver license verification requirements.
  - All providers that previously failed to satisfy the background check requirement and all new providers must complete the background check process through the Employment Controls and Compliance Unit (ECCU) at the Department of Human Services' approved vendor.
  - Copies of a successful background check, valid driver's license and proof of highest educational level obtained must be submitted to CSOC to grant employees access to CYBER.

NEWSLETTER UPDATE

- Providers shall provide proof of driver's licenses annually for all active employees whose job responsibilities may require them to transport Medicaid/NJ FamilyCare members.
- This shall include attestations that the licenses were in the staff members' possession and that the license was physically reviewed and noted to have a future expiration date.
- Staff with license expiration dates within two months of the license examination date should present a copy of the renewed license upon renewal.
- The required verification documentation form, available on the DCF website, shall be submitted electronically to CSOC's Office of Community Services, Provider Enrollment Unit every January.

QUALIFICATIONS AND BACKGROUND CHECKS

Provider is responsible to verify and maintain a copy of documentation that:

- Staff is qualified and trained - verify credentials, certification, licenses, establish training schedule
- Ensure that new or potential staff have no disqualifying criminal issues before permitting provision of services
  - FARA- Once the staff complete the fingerprint process, they can retrieve a copy of their “cleared” letter from ECCU’s on-line Fingerprint Approval Retrieval Application (FARA) website. Instructions can be found at: https://www.nj.gov/humanservices/staff/opia/cfu/fara.html

PUBLIC HEALTH EMERGENCY (PHE)

- DOH health care provider requirements
  - 6 ft spacing
  - Masks
  - Mandatory vaccines for staff
- Telehealth-currently allowed in response to the PHE.
  - Temporary Telehealth Guidelines: Newsletter Volume 30 Number 9
- Telehealth law (2021)- guidance after current waivers affecting telehealth are lifted.

COMPLIANCE AND THE MEDICAID FRAUD DIVISION

Presented by: The Medicaid Fraud Division

SIX STEPS TOWARDS COMPLIANCE

1. Providing the clinically appropriate service as identified in the treatment plan
2. Accurately documenting the services - who, what, where, when and how
3. Instituting Responsible Billing Practices
4. Properly Supervising all Employees' Provision of Services
5. Establishing a System to Identify and Correct Errors and Omissions concerning Credentialing, Documentation and Billing
6. Adhering to Waiver and Regulatory Standards, where applicable, including hiring practices, properly completing Medicaid application, and training yourself and all staff about their requirements

CONSEQUENCES

Non-compliance with Medicaid rules, standards and regulations regarding service may constitute acts of fraud, waste or abuse of Medicaid funds.

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

- New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. 30:4D-53 et seq. established the Office of the Medicaid Inspector General to detect, prevent, and investigate Medicaid fraud and abuse, recover improperly expended Medicaid funds, enforce Medicaid rules and regulations, audit cost reports and claims, and review quality of care given to Medicaid recipients.

- These functions, powers and duties were later transferred to the Office of the State Comptroller (OSC), and are carried out by the Medicaid Fraud Division (MFD).

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

The Medicaid Fraud Division:

- performs program integrity functions;
- conducts audits and investigations of potential fraud, waste and abuse by providers and recipients; and
- coordinates program integrity oversight efforts among all State agencies that provide and administer Medicaid services and programs.

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

The Medicaid Fraud Division also:

- works to recover improperly expended Medicaid funds;
- enforces Medicaid rules and regulations;
- audits cost reports and claims;
- reviews the quality of care given to Medicaid recipients; and
- excludes or terminates providers from the Medicaid program where necessary.

WHAT IS: FRAUD, WASTE, AND ABUSE?

Presented by: UnitedHealthcare Community Plan

FRAUD
N.J.S.A. 30:4D-55

Fraud – is an intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit to that person or another person, including any act that constitutes fraud under applicable federal or State law.

CIVIL MEDICAID FRAUD, WASTE AND ABUSE CONSEQUENCES

- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Referral for criminal prosecution
- Restitution/Recovery of overpayments
- Additional penalties in addition to repaying Medicaid overpayments

WASTE

- Waste is generally understood to encompass overutilization or the misuse of resources.
- Waste is not *usually* considered a criminal act.
- Waste is considered a legal violation for civil purposes and can result in a recovery of an overpayment, debarment from the Medicaid program and penalties.

ABUSE
N.J.S.A. 30:4D-55

- Abuse - provider practices that are inconsistent with proper, sound fiscal, business, or professional or service delivery practices that result in:
  - unnecessary costs to or improper payment by Medicaid

    OR
  - reimbursement for services that are not necessary, not approved, not documented, that are outside those specifically authorized

WASTE AND ABUSE - PROFESSIONAL DUE DILIGENCE

Business practices that result in **waste and abuse** can rise to the level of **fraud:**

- Providing service without proper authorization (unless it is emergent care)
- Using unlicensed, unqualified, or untrained staff
- Inaccurate / incomplete documentation of service
- Billing for undocumented / unsubstantiated services
- Insufficient internal checks and balances

AUDIT FINDINGS: EXAMPLES

Presented by: The Medicaid Fraud Division

EXAMPLES: BEHAVIORAL ASSISTANT AUDIT FINDINGS

- Criminal Background Checks
  - Regulations N.J.A.C. 10:77-4.9(g) and N.J.A.C. 10:77-4.14(d)(2)
  - Did not obtain criminal background checks
  - Criminal background checks subsequent to the BA providing services
    - Example – service was rendered on June 27, 2017, but the background check was not conducted till February 4, 2021, nearly four years after the date of service.

EXAMPLES: BEHAVIORAL ASSISTANT AUDIT FINDINGS

- Behavioral Assistance Training Certifications
  - Regulation N.J.A.C. 10:77-4.14(c)(4)
  - Did not obtain behavioral assistance training certifications
  - Behavioral assistance training certifications not obtained within six months of BA's hire date
    - Example – BA rendered service without obtaining behavioral assistance training certification within 6 months of hire date
  - Training sessions attendance is not adequate to satisfy this requirement, a course test must be passed and training certificate must be maintained by the provider
  - BAs must be re-certified annually before the expiration date of their prior certificate

EXAMPLES: BEHAVIORAL ASSISTANT AUDIT FINDINGS

- Education
  - Regulations N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)(1)
  - Did not maintain proof of education
    - Example – Providers reaching out to their employees only after audit was initiated and no proof of education was maintained at time of hire

- Current and Valid Driver's License
  - Regulations N.J.A.C. 10:77-4.9(f) and N.J.A.C. 10:77-4.14(d)(1)
  - Did not maintain a driver's license
    - Example – Providers maintaining only the driver's license obtained at time of hire and not any subsequent documentation, after the original had expired

EXAMPLES: BEHAVIORAL ASSISTANT AUDIT FINDINGS

- Proof of minimum age
  - Regulations N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)
  - Did not maintain proof of age
    - Example – BA rendering services at 19 years of age while the regulation states a minimum age of 21

EXAMPLES: INTENSIVE IN-COMMUNITY AND BEHAVIORAL ASSISTANCE AUDIT FINDINGS

- Unlicensed Professionals (IIC)
  - Regulations N.J.A.C. 10:77-5.7(d) and N.J.A.C. 10:77-5.14(b)
  - Unlicensed professionals rendering services
  - Obtained license subsequent to the servicing provider providing services
    - Example - service was rendered on January 1, 2020, but the license was obtained on June 30, 2020, 6 months after the service date.

- Service Delivery Encounter Documentation (SDED) Forms
  - Regulations N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:77-4.12(d)(3), -(5), and N.J.A.C. 10:77-5.12(d)(3), -(5)
  - Composed of two pages
  - Must be accurately completed
  - Must be maintained for every service encounter

EXAMPLES: INTENSIVE IN-COMMUNITY AND BEHAVIORAL ASSISTANCE AUDIT FINDINGS – SDED CONTINUED

- Billed for services provided at the same or overlapping times
  - Example – one SDED documented services on January 25, 2019, from 6:00 PM to 8:30 PM
  - Second SDED documented services to a different Medicaid beneficiary from 6:00 PM to 8:30 PM, by the same servicing provider
  - Resulting in an overlap of services
- Billed for travel time
  - Example - one SDED form documented services on July 19, 2019, from 8:30 AM to 10:30 AM
  - Second SDED form documented services to a different beneficiary from 10:30 AM to 12:30 PM, by same servicing provider
  - Two service encounter locations were more than 62 miles apart

EXAMPLES: INTENSIVE IN-COMMUNITY AND BEHAVIORAL ASSISTANCE AUDIT FINDINGS

- Progress Notes
  - Regulations N.J.A.C. 10:49-9.8(b)(1), N.J.A.C. 10:77-4.12(e)(6), and N.J.A.C. 10:77-5.12(e)(6)
  - Progress notes and SDED forms are different requirements
  - Must document services provided through progress notes
    - Did not maintain progress notes
    - Did not capture information pertinent to the beneficiary's response to treatment, etc.
    - Duplicated progress notes / copied from one encounter to the other

MEDICAID FRAUD DIVISION: ACTIONS, EXCLUSIONS AND SELF-DISCLOSURES

Presented by: The Medicaid Fraud Division

MFD RECOVERY ACTIONS

Once an overpayment has been identified as a result of an investigation or audit, MFD initiates actions for recoupment of improperly paid funds:

- ✓ MFD will send a Notice of Estimated Overpayment or Notice of Intent and, if necessary, a Notice of Claim
- ✓ MFD may add penalties, including false claim penalties between $11,181 and $22,363 per claim
- ✓ MFD may file a Certificate of Debt on real estate property owned by a provider/owner of business
- ✓ MFD may seek a Withholding of future Medicaid payments until the overpayment is satisfied

EXCLUDED, SUSPENDED OR DISQUALIFIED PROVIDERS

- A debarred, suspended or excluded provider is a person or an organization that has been excluded from participation in Federal or State funded health care programs

- Any products or services that a debarred provider directly or indirectly furnishes, orders or prescribes are not eligible for payment under those programs

- It is incumbent upon providers to perform Exclusion Checks, upon hire and monthly thereafter
  - NJMMIS Newsletter Volume 26, Number 14

MEDICAID EXCLUSION LIST REQUIREMENTS

1. State of New Jersey debarment list (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
2. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
3. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
4. N.J. Division of Consumer Affairs licensure databases (mandatory): http://www.njconsumeraffairs.gov/Pages/verification.aspx
5. N.J. Department of Health licensure database (mandatory):http://www.state.nj.us/health/guide/find-select-provider/
6. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp
7. If the provider is out of state, you must also check that state's exclusion/debarment list

SELF-DISCLOSURE

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://nj.gov/comptroller/resources/#collapseSub30/

- Affordable Care Act §6402 and N.J.A.C. §10:49-1.5 (b)(1), (7)
  - require that any overpayments from Medicaid and/or Medicare must be returned within 60 days of identifying that they have been improperly received.

- Providers who follow the protocols for a proper self-disclosure can avoid imposition of penalties.

- MFD's Self Disclosure Form: https://nj.gov/comptroller/news/docs/self_disclosure_form.pdf

THIRD-PARTY LIABILITY (TPL)

- Third-Party Liability exists when any entity or party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program.
  - Examples: Medicare, commercial health insurance, Tricare
- By law, Medicaid is the payer of last resort. All TPL shall, if available, be used first and to the fullest extent to pay claims before Medicaid/NJ FamilyCare pays for the care of the Medicaid recipient.
- It is a violation of Section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services (N.J.A.C. 10:49-7.3).

Name	Contact Information
TPL Hotline	(609) 826-4702
TPL Hotline en Español	(609) 777-2753

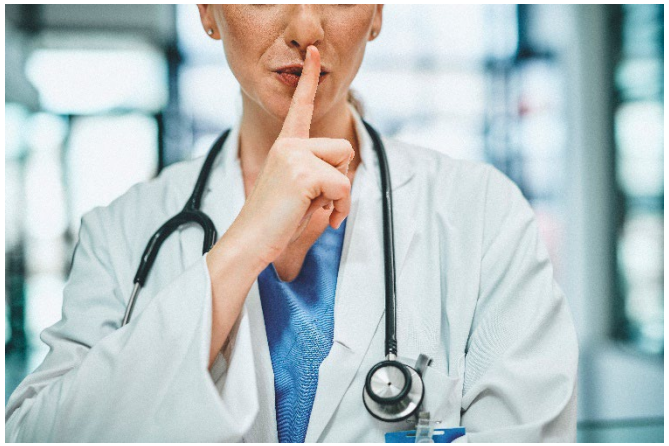
MEDICAID FRAUD CONTROL UNIT (MFCU)

Presented by: The Medicaid Fraud Control Unit

MEDICAID FRAUD CONTROL UNIT (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud (OIFP) is the criminal oversight entity.



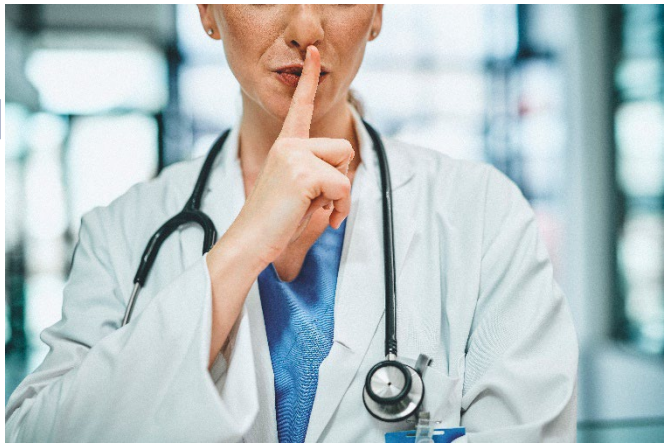
- MFCU investigates and prosecutes Medicaid Fraud.

- The MFCU utilizes attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

MEDICAID FRAUD CONTROL UNIT (MFCU)

The MFCU investigates and prosecutes alleged criminal actions:

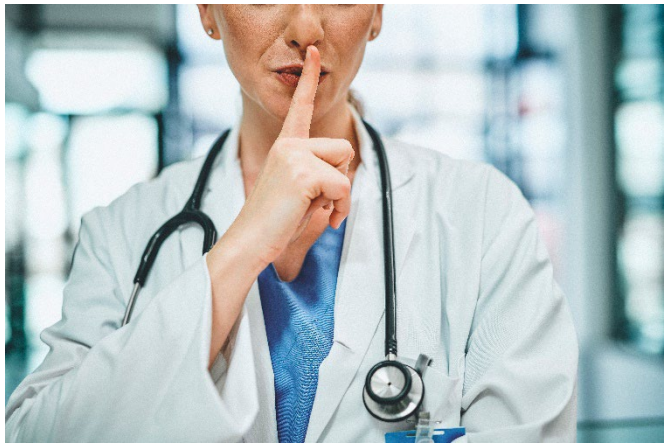
- Allegations of physical abuse to beneficiaries
- Healthcare Providers who are suspected of defrauding the Medicaid Program
- Fraudulent activities by providers against the Medicaid program.
- Fraud in the administration of the program.
- Fraud against other federally or state funded health care programs where there is a Medicaid nexus.



CRIMINAL HEALTH CARE CLAIMS FRAUD

N.J.S.A. 2C:21-4.3

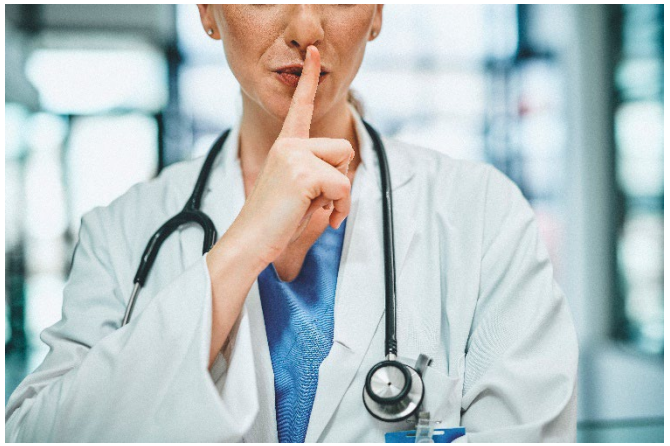
- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license



FALSE CLAIMS

Did you know…

- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.



- Willful ignorance of the truth or falsity of a claim is not a defense.

- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.

MEDICAID FRAUD

Bottom line:

Ignorance of the law excuses no one.

It is the provider's responsibility to know the laws.

WRAP UP

QUESTIONS? PLEASE CONTACT US!

- Division of Medical Assistance and Health Services (DMAHS)
  - Website: https://www.state.nj.us/humanservices/dmahs/home/index.html
- Medicaid Fraud Division (MFD)
  - Email: provider-education@osc.nj.gov
  - Website: https://nj.gov/comptroller/about/work/medicaid/
- Medicaid Fraud Control Unit (MFCU)
  - Email: NJMFCU@njdcj.org
  - Website: https://www.nj.gov/oag/medicaidfraud/

QUESTIONS? PLEASE CONTACT US!

- Department of Children and Families (DCF)
  - Website: https://www.nj.gov/dcf/
- For general IIC questions, please contact DCF IIC Provider Communications at:
  - Email: iicprovider.ommunications@dcf.nj.gov
  - Wyndee Davis: wyndee.davis@dcf.nj.gov
  - Kelly Figueroa: kelly.figueroa@dcf.nj.gov

MFD FRAUD HOTLINES

Name	Contact Information
Aetna Better Health of New Jersey	(855) 282-8272
Amerigroup New Jersey, Inc.	(866) 847-8247
Horizon NJ Health	(877) 378-5292
UnitedHealthcare Community Plan	(844) 359-7736 https://www.uhc.com/fraud
WellCare Health Plans of NJ, Inc.	(866) 678-8355
Liberty Dental Plan	(888) 704-9833 Compliancehotline@libertydentalplan.com
NJ Medicaid Fraud Control Unit	(609) 292-1272 NJMFCU@njdcj.org

HOW DID WE DO?

Please respond to a brief poll to help us know how we did!

QUESTIONS?

Any questions we are unable to answer today, please submit in writing to:

provider-education@osc.nj.gov

APPENDIX

IIC Service Delivery – N.J.A.C. 10:77 4-5

The following information is current as of the time of the presentation and is subject to change:

- 5.3 Provider Participation Requirements – Required agency status and staff credentials, experience; potential penalties when operating outside of the regulations
- 5.4 Beneficiary Eligibility – Prior Authorization requirement; clinical criteria
- 5.5 Beneficiary Rights – References CSOC values and principles
- 5.6 General Program Description – Outlines in person, in community service delivery, IIC goal and length of service, family involvement requirement and allowances, allowances as transition support plan

IIC Service Delivery – N.J.A.C. 10:77 4-5

- 5.7 Program Description – Describes levels of IIC Service, supervision requirement - One hour per 40 hours or per month.
- 5.8 Individual Service Plan – Outlines scope of interventions and requirement of specific interventions, definable outcomes and identified strategies, timeframes, credentials, delivery within an approved, comprehensive plan.
- 5.9 Staff Requirements – administrative oversight: Master's Degree in relevant field + 3 years experience delivering mental health services and position requirements; clinical oversight: education and experience required and practicing in line with NJ licensing board regulations; criminal background check.
- 5.10 Authorization for Service

IIC Service Delivery – N.J.A.C. 10:77 4-5

- 5.11 Reimbursement
- 5.12 Record Keeping; beneficiary
- 5.13 Outcomes – Requires provider participation in tracking improvement related to CSOC goals.
- 5.14 General Recordkeeping – Human Resource required documentation – Includes credentials.
- *Subchapter 4 houses Behavioral Assistant (BA) Regulations with similar topics which outline requirements for BA service delivery.*

KEEP IN TOUCH

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