# Medicaid Fraud Division

## Mental Health and Substance Abuse Providers

## Useful Tools for a Compliant Medicaid Practice

December 6, 2017

# Disclaimer

- The information contained within this presentation is provided for general information only and does not constitute legal or regulatory advice. Any views or opinions presented are solely those of the presenter(s) and do not represent those of UnitedHealth Group, Horizon NJ Health, etc. (collectively referred to as Medicaid). UnitedHealth Group, Horizon NJ Health, etc. its officers, employees, and agents do not intend that anyone should rely on any information contained within this presentation in any manner. UnitedHealth Group, Horizon NJ Health, etc. and its officers, employees, and agents do not assume, and hereby expressly disclaim, liability for use of or reliance on the information contained within this presentation, and specifically disclaim any guarantee, warranty, or representation that implementation may have.
- The information contained herein may not apply to any specific factual or legal circumstances, nor should the description of any specific case or set of facts or circumstances be construed as a prediction that a similar outcome could be expected if the case or facts occurred again. The outcome of every case is dependent upon the facts and circumstances surrounding that particular case and will differ from case to case. This information is not intended to substitute for obtaining legal advice from an attorney and no person should act or rely on any information from this presentation without seeking the advice of an attorney.
- Presentations are intended for educational purposes only and do not replace independent professional judgment.

# Goals For Today

To help you better understand:

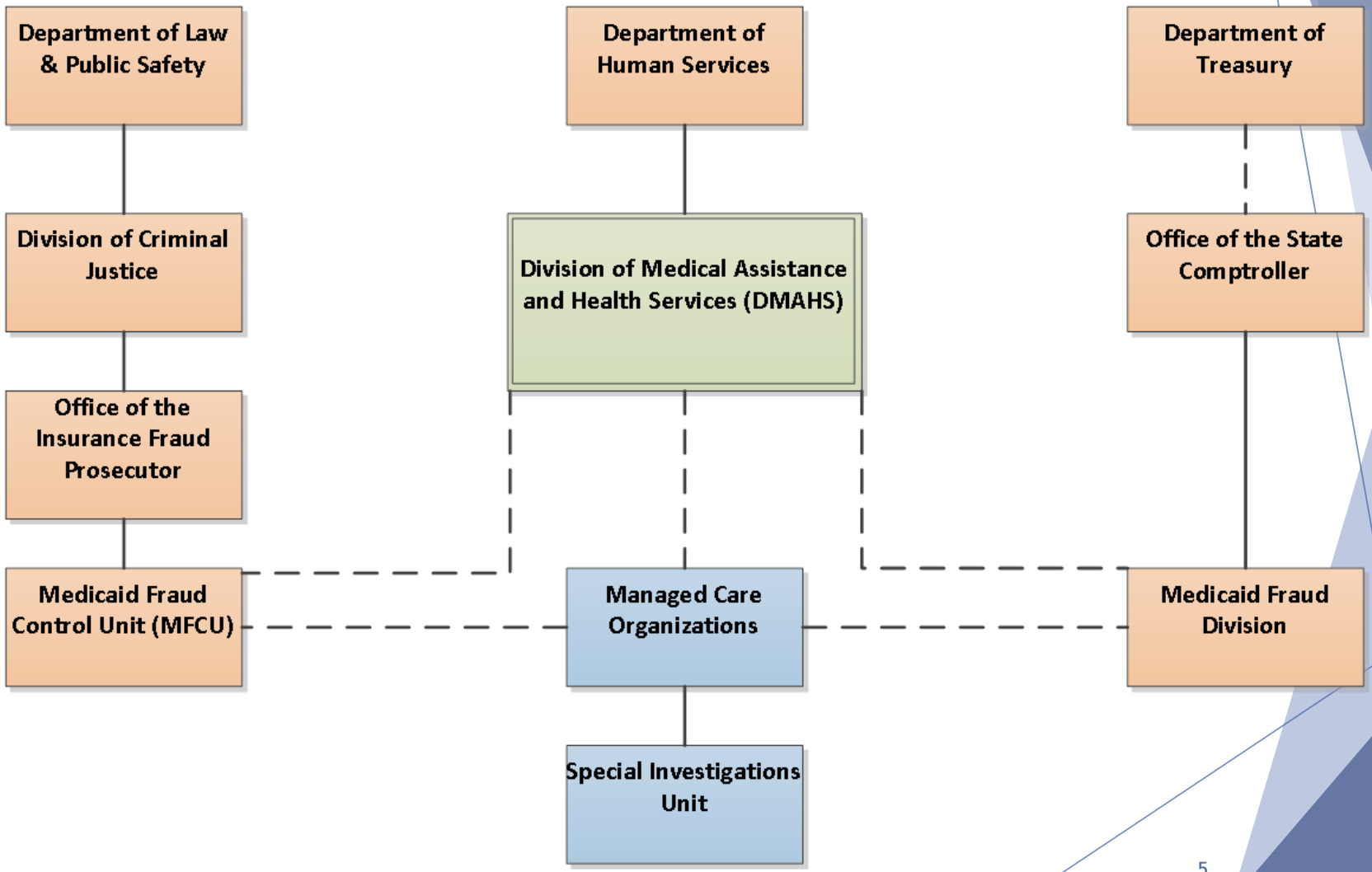
- The Medicaid regulatory framework
- Medicaid documentation requirements for Mental Health/Substance Abuse Providers
- Fraud, waste and abuse obligations
- Consequences for non-compliance

# What is Medicaid?

- Medicaid is a joint Federal and State program that helps pay medical costs if individuals have limited income and resources or meet other requirements.


- Medicaid is a voluntary program.  If you want to participate, you must know, accept and abide by the rules and regulations.

# Administration & Oversight



# State Licensing Requirements

***N.J.S.A.*** 45:1-1 et seq. State statutes applicable to each profession

e.g. ***N.J.S.A.*** 45:9-1 et seq. Board of Medical Examiners

N.J.A.C. State regulations pertaining to Board of Medical Examiners, Nurse Practitioners, Marriage and Family Therapy, Licensed Social Workers, Psychology

# New Jersey Behavioral Health and Substance Abuse Disorder (SUD) Service Delivery

- New Jersey Medical Assistance and Health Services (DMAHS) New Jersey Family Care (Medicaid)

www.state.nj.us/humanservices/dmahs/home

Fee for Service Managed Care

- New Jersey Department of Health Division of Mental Health and Addiction Services

http://nj.gov/health/integratedhealth/

- New Jersey Children's System of Care

http://www.performcarenj.org/provider/index.aspxRecordkeeping

# State Regulatory Scheme

- Department of Law and Public Safety
  - Division of Consumer Affairs
  - Professional Boards
  - Licensing Standards
  - Professional Misconduct or other violations
  - Recordkeeping
  - Duty to Cooperate

# Medicaid Managed Care Contract

The New Jersey Department of Human Services, DMAHS, has a contract with the following MCOs:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare Health Plans of NJ, Inc.

# Documentation

## Mental Health and Substance Abuse Providers

# Medicaid Documentation Requirements N.J.A.C. 10:49-9.8

- Providers shall agree to the following:
  - To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
  - To furnish information for such services as the program may request;
  - That where such records do not document the extent of services billed, payment adjustments shall be necessary;

# Medical Record Documentation Requirements

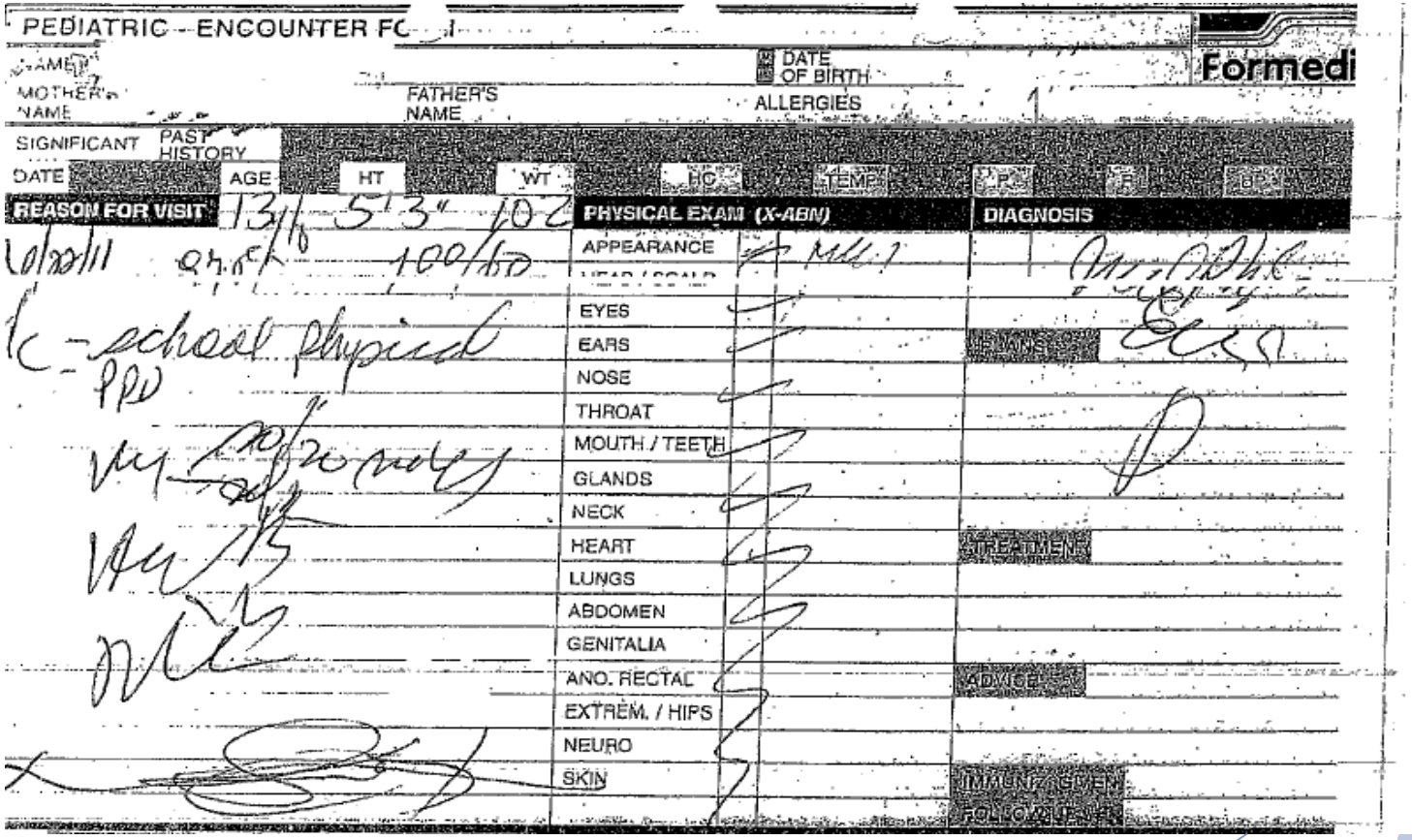
- There are generally two types of medical records, either handwritten or Electronic Health Records (EHR).

- Regardless of the type of record the content must be accurate and complete.  It is a record of what occurred and it is very important for continuity of care and also to support that the services billed were rendered.

# Documentation Standards

- All records must include:
  - Patient's name
  - Date of service
  - Signature of person making the entry
- Handwritten Records:
  - Must be legible as to contents and signature
  - Record must reflect all elements of what provider bills
  - Should be done contemporaneously or as close to that as possible

# Documentation must be legible


PEDIATRIC – ENCOUNTER FC

NAME

MOTHER'S NAME

FATHER'S NAME

DATE OF BIRTH

ALLERGIES

Formedi

SIGNIFICANT PAST HISTORY

DATE | AGE | HT | WT | HC | TEMP | P | R | B

REASON FOR VISIT | PHYSICAL EXAM (X-ABN) | DIAGNOSIS

10/20/11 | 13 y/o | 5'3" | 102 | 100/60

APPEARANCE

EYES

EARS

NOSE

THROAT

MOUTH / TEETH

GLANDS

NECK

HEART

LUNGS

ABDOMEN

GENITALIA

ANO. RECTAL

EXTREM. / HIPS

NEURO

SKIN

TREATMENT

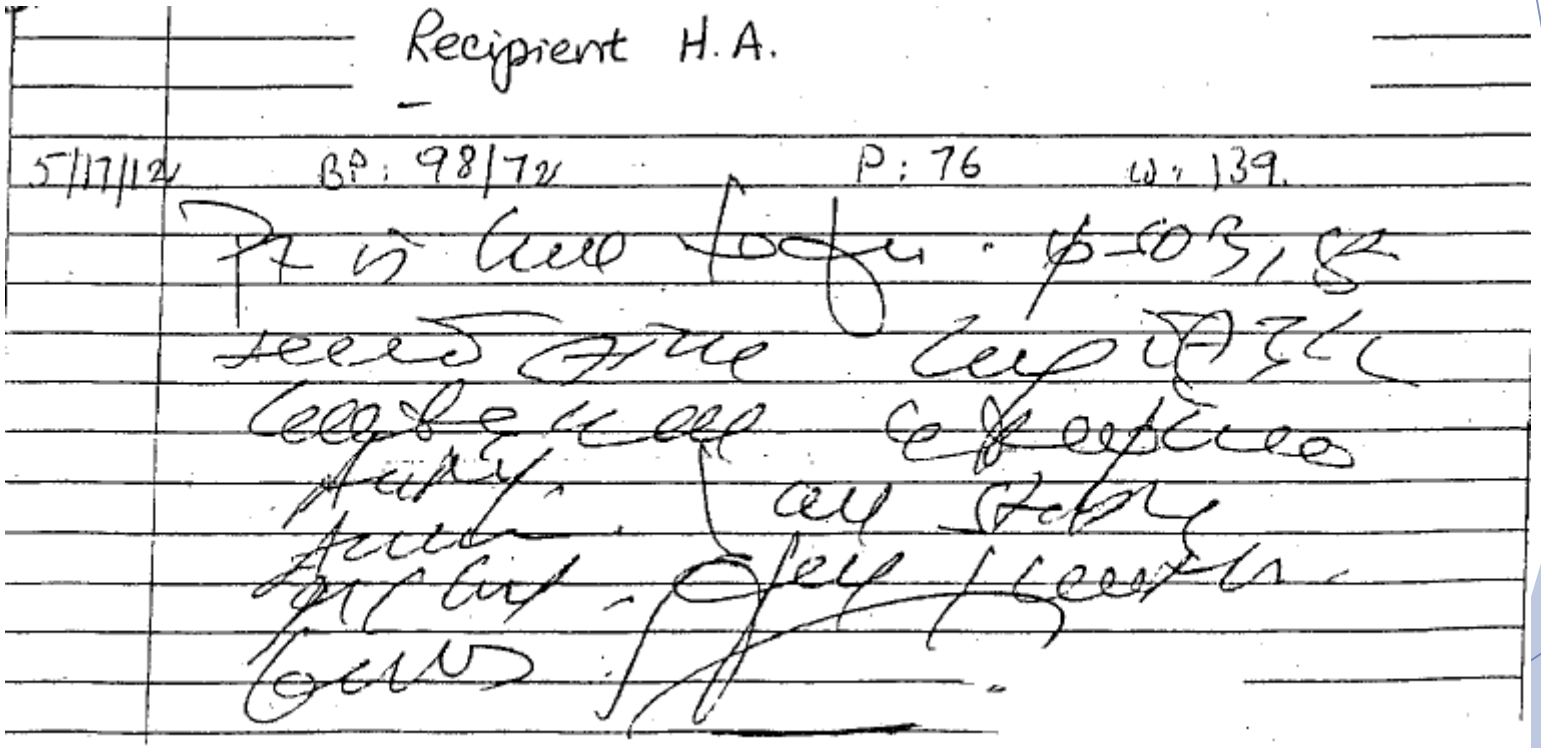
ADVICE

IMMUNIZATION

FOLLOW UP

**The records must be legible to someone other than the author.**

# This Record…


Recipient H.A.

5/17/12 BP: 98/72 P: 76 W: 139.

# Became…This Record

05/17/2012

H; ; A; DOB: FEMALE

HT: 5.0 BP: 98/78 P:76 WT : 138

PATIENT IS HERE TO FOLLOW UP, NO CHEST PAIN OR SHORTNESS OF BREATH.

H.E.E.N.T. ATRAUMATIC NORMAL CEPHALIC . LUNGS CLEAR TO AUSCULATIONS

BILATERALL. HEART SOUND 1, SOUND 2, REGULAR RATE AND RHYTHM ABDOMEN SOFT

NONTENDER. BOWEL SOUNDS POSITIVE. EXTREMITIES: NO EDEMA, CLUBBING OR

CYANOSIS

ASSESTMENT PLAN -

1. ANXIETY
2. ANEMIA
3. GERD
4. HYPERLIPIDIMIA

STABLE CONTINUE ALL MEDS AS ORDERED AND FOLLOW UP IN ONE MONTH.

**Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialed by the licensee.**

# Electronic Health Record

- Must be accurate and the provider needs to be aware of the inaccuracies caused by:
  - Cloning
  - Pulling forward information from last visit
  - Cut and Paste
  - Templates
- A provider must seek appropriate training on the EHR system that it is using. However, it is **NOT** the responsibility of the software vendor to instruct the provider on which codes to use.

# Mental Health Services
## *Documentation*

- The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself
- The date and time that services were rendered
- The duration of services provided (one hour, 1/2 hour, etc.); the session start and stop times
- The signature of the practitioner or provider who rendered the services and their credentials
- The setting in which services were rendered
- A notation of progress, impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care

# Incorrect Progress Note Example

**Progress Note**

INTERVAL HISTORY:

DIAGNOSES: The following Diagnoses are based on currently available information and may change as additional information becomes available.

**ADHD, Predominantly Inattentive Presentation, 314.00 (F90.0) (Active)**
**Anxiety Disorder, Other Unspecified Anxiety Disorder , 300.00 (F41.9) (Active)**
**Bipolar and Related Disorder due to other, unspecified bipolar and related disorder, 296.80 (F31.9) (Active)**

99214 (Office Pt, Established) - SA
90836 Psychotherapy 45 min. with EM services - SA

# SAMPLE MENTAL HEALTH PROGRESS NOTE

**Date of Exam:** 3/16/2012
**Time of Exam:** 3:20:41 PM

**Patient Name:** Smith, Anna
**Patient Number:** 1000010544165

Anna shows minimal treatment response as of today. Anna continues to exhibit symptoms of a generalized anxiety disorder. Symptoms continue the same in frequency and intensity, and no significant improvement is noted. Symptoms of this disorder occur more days than not. Sleep difficulty continues unchanged. Feelings of increased muscular tension across neck and shoulders continue unchanged. Anna describes feeling irritable. Continuing difficulty concentrating is described. Feelings of fatigue are described as continuing unchanged.

Medication has been taken regularly. She has to force herself to socialize with others. A fair night's sleep is described. Sleep was not continuous and not completely restful.

**Content of Therapy:** Anna admitted to feeling overwhelmed and anxious even when completing the smallest project. Becoming easily frustrated was also discussed by the patient. "When will this jumpiness end?"

**Therapeutic Interventions:** The main therapeutic techniques used this session involved helping to identify areas of difficulty and to develop coping skills and to manage stress. This session the therapeutic focus was on improving the patient's self-compassion. Patient will make positive statements regarding self and the ability to cope with the stresses of life.

**MENTAL STATUS:** Anna is irritable, distracted, and fully communicative, casually groomed, and appears anxious. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood is entirely normal with no signs of depression or mood elevation. Her affect is congruent with mood. There are no signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content is appropriate. Homicidal ideas or intentions are convincingly denied. Cognitive functioning and fund of knowledge is intact and age appropriate. Short and long term memory is intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Clinically, IQ appears to be in the above average range. Insight into illness is fair. Social judgment is intact. There are signs of anxiety. Anna is fidgety.

**DIAGNOSES:** The following Diagnoses are based on currently available information and may change as additional information becomes available.

Axis I: Generalized Anxiety Disorder, 300.02 (Active)

**INSTRUCTIONS / RECOMMENDATIONS / PLAN:**

Link to Treatment Plan Problem: **Anxiety**

Short Term Goals:
Anna will have anxiety symptoms less than 50% of the time for one month.
Target Date: 4/25/2012

In addition, Anna will exhibit increased self-confidence as reported by client on a self-report 0-10 scale weekly for two months.
Target Date: 5/23/2012

---

No progress in reaching these goals or resolving problems was apparent today.
Recommend continuing the current intervention and short term goals. It is felt that more time is needed for the intervention to work.

Return 1-2 weeks or earlier if needed.

90805 (psychotherapy w. E/M services)

Time spent counseling and coordinating care: 45-50 min

Session start: 2:00 PM
Session end: 2:50 PM

*Liz Lobao, MD*

Electronically Signed
By: Liz Lobao, RN

# ***If it's not documented, it wasn't done.***

Medical records must accurately reflect the services that were rendered.

# Billing and Coding

- The use of codes by the provider is ***to accurately report the services rendered and to receive payment for those services***. The codes that are used on the claim form are:
  - American Medical Association (AMA)/Current Procedural Terminology (CPT) codes
  - Healthcare Common Procedure Coding System (HCPCS) codes
  - International Classification of Diseases ICD-9/ICD-10

# Billing and Coding

It is the **Provider's** responsibility to ensure that claims submitted for payment reflect the actual service that was provided.  It is incumbent upon **Providers** to be knowledgeable regarding the codes that are used to reflect the services rendered!!!

# Claims Submission Requirements

***Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties***

- **SIGNATURE OF PHYSICIAN (or SUPPLIER)**: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

- **NOTICE**: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal or State laws.

# Fraud, Waste and Abuse

# Fraud

*Fraud* - 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.

- ***N.J. Stat. § 30:4D-55***

# Waste

*Waste* is not defined in the rules, but is generally understood to encompass overutilization, underutilization or misuse of resources.

Waste is not usually a criminal or intentional act.

**CMS's Fraud, Waste and Abuse Toolkit**
**https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf**

# Abuse

*Abuse* - provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to Medicaid or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

The term also includes recipient practices that result in unnecessary costs to Medicaid.

- ***N.J. Stat. § 30:4D-55***

# Third Party Liability

## Medicaid Fraud Division

# Third Party Liability

…exists when any party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid or NJ Family Care program.

**N.J.A.C. 10:49-7.3**

# Third Party Liability

Medicaid and NJ Family Care (NJFC) benefits are **last** payment benefits. All Third Party Liability (TPL) must be used first and to the fullest extent in meeting the costs of the medical needs of a beneficiary.

A TPL's potential liability to pay for services **cannot** prevent a Medicaid beneficiary from receiving covered services.

**N.J.A.C 10:49-7.3**

# Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

**1.** For services, goods or supplies not covered or authorized by the NJ Medical Assistance and Health Services Act or by the Division of Medical Assistance and Health Services…

**AND** if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

**AND** if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

**AND** the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

**N.J.A.C 10:74-8.7**

# Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

**2.** The provider does not participate in Medicaid and NJFC either generally or for that service…

**AND** if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

**AND** if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

**AND** the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

**N.J.A.C. 10:74-8.7**

# Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

**3.** For payments made to the beneficiary by a third party on claims submitted to the third party by the provider.

**4 .** For NJFC Plan C enrollee's contribution to care responsibility and for NJFC Plan D enrollee's required copayment.

**N.J.A.C. 10:49-7.3**

# MFD Audits and Investigations

## Mental Health and Substance Abuse Providers

# Medicaid Fraud Division Audits & Investigations

Review Period

*N.J. Stat. § 2A:14-1.2 (2016)*

- 10 year statute of limitation
- MFD has the capability to review records as far back as 2006

*N.J. Stat. § 30:4D-12 (2016)*

- Records must be retained for at least 5 years from the date the service was rendered
- Records must include:
  - Name of the recipient
  - Date of service
  - Nature and extent of each service
  - Any additional information that may be required by regulation

# Medicaid Fraud Division Audits & Investigations

Relevant Statutes

*N.J.A.C. 10:49-9.8 (2016)*

- All providers shall certify that the information furnished on the claims is true, accurate, and complete.
- Providers must keep such records as are necessary to disclose fully the extent of services provided
    - Ex. Invoices serve as one form of proof that you purchased and supplied a Medicaid beneficiary with DME or Medical Supplies
- All employees, contractors, or subcontractors shall meet all the requirements of the Medicaid or NJ FamilyCare programs
- Must ensure all individuals or entities have current/ valid licenses and certifications (also includes equipment and vehicles)

# Medicaid Fraud Division Audits & Investigations

Relevant Statutes Continued

*N.J.A.C. 10:49-5.5 (2016)*

- Services not covered by Medicaid if
  - No medical necessity
  - No prior authorization
  - Records inadequate and illegible
  - Prescribing Physician excluded from participation in Medicaid

**NOTE:** This is not the complete list of non-covered services. The full list consists of 18 items and can be found in the Administrative Code section listed above.

# 10 Minute Break? Keep going?


# Consequences

# Medicaid Insurance Fraud is a Serious Crime

- The MFCU in the Office of the Insurance Fraud Prosecutor (OIFP) investigates and prosecutes Medicaid Fraud.
- The MFCU utilizes Attorneys, Investigators, Nurses, Auditors and other support staff to police the Medicaid system.

# Medicaid Fraud (*N.J.S.A.* 30:4D-17)

- It is illegal to knowingly and willfully make or cause to be made any false statement in a claim.
- It is illegal to over bill Medicaid for services provided or services that were not received.
- It is illegal to participate in a scheme to offer or receive kickbacks or bribes in connection with the furnishing of items or services that are billable to Medicaid.

# Medicaid Fraud Consequences

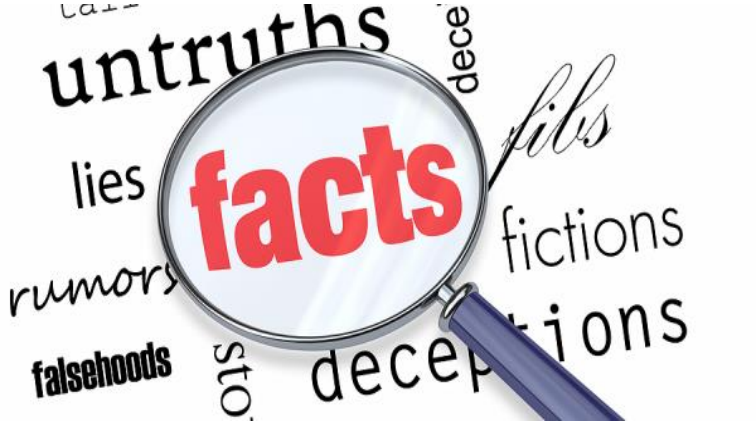
- Punishable by up to 5 years in state prison
- Mandatory penalty up to $25,000 for each violation
- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Restitution/Recovery of overpayments

# 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

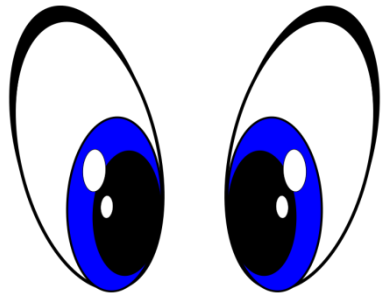
# Did you know…

- 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.



# Whistleblower/Qui Tam

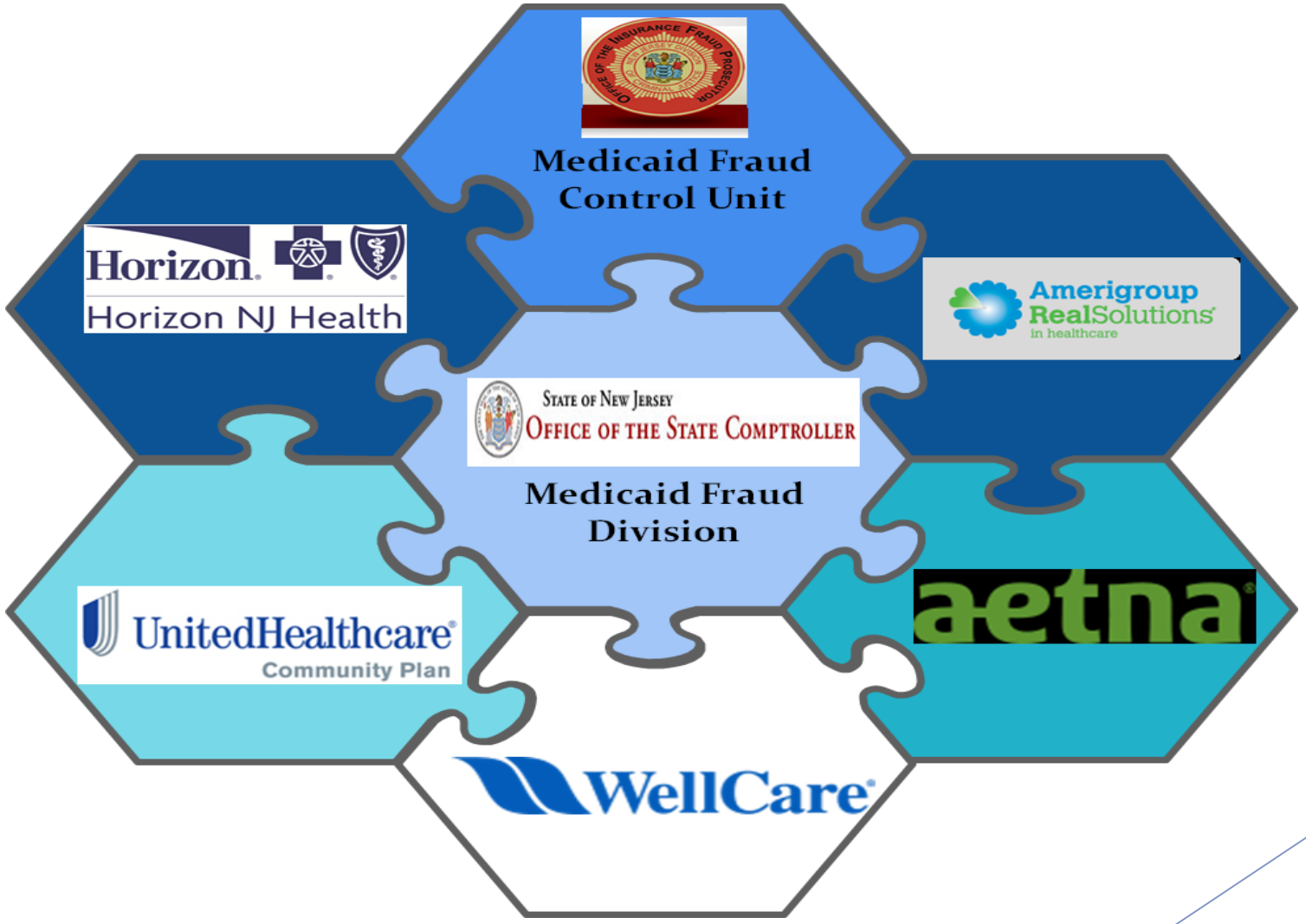
- Empowers people to file civil suit against individuals and companies that defraud the federal, state or local government.
- A person filing suit might be eligible for up to a 30 percent share of the recovery.
- A person filing suit might be protected from being fired or retaliated against by their employer for reporting fraud and abuse to authorities.



# “Ignorance of the law excuses no one.”

# Conclusion

# MFD Brings MCOs Together Regularly to Discuss FW&A Issues



# Affordable Care Act

- 42 CFR §455.450 contains the screening requirements for providers who wish to enroll in the Medicaid program

# Debarred Providers

- A debarred 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

# Self-Disclosure

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments.

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

- Failure to return an overpayment makes you liable to the imposition of penalties of $5,500 to $11,000 per claim

# Self-Disclosure

- MFD's self-disclosure policy is more liberal than OIG's policy
- If MFD agrees with your analysis, we do not impose interest or penalties
- MFD's Self-Disclosure policy can be found on our website, www.nj.gov/comptroller/divisions/medicaid/disclosure

# MFD Recovery Actions

- Once an overpayment has been identified as a result of an investigation, actions to initiate recoupment of the funds will take place
  - MFD will send a Notice of Estimated Overpayment or Notice of Intent and, if necessary, a Notice of Claim
  - MFD may add false claim penalties between $5,500 and $11,000

# Questions

- Thank you for attending!
- Your opinion matters.  Please complete your evaluation form before you leave.