Steering Clear of Medicaid Fraud, Waste and Abuse

Presented by the New Jersey Department of Human Services
Division of Developmental Disabilities

in partnership with

The Office of the State Comptroller
Medicaid Fraud Division

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.

Goals for Today

To help you better understand:

- DDD provider responsibilities for Medicaid compliance
- Medicaid and DDD documentation requirements for payment
- DDD provider obligation to avoid fraud, waste or abuse of Medicaid funds
- Medicaid and DDD regulatory and program integrity oversight
- Consequences for non-compliance

What is Medicaid?

- Medicaid is a joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals, including those who meet DDD eligibility requirements.

- 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.

Essential Information

Rendering services that fail to meet all Medicaid, Waiver and related requirements do not qualify as billable services.

It is the provider's responsibility to know and comply with documentation, service and billing requirements.

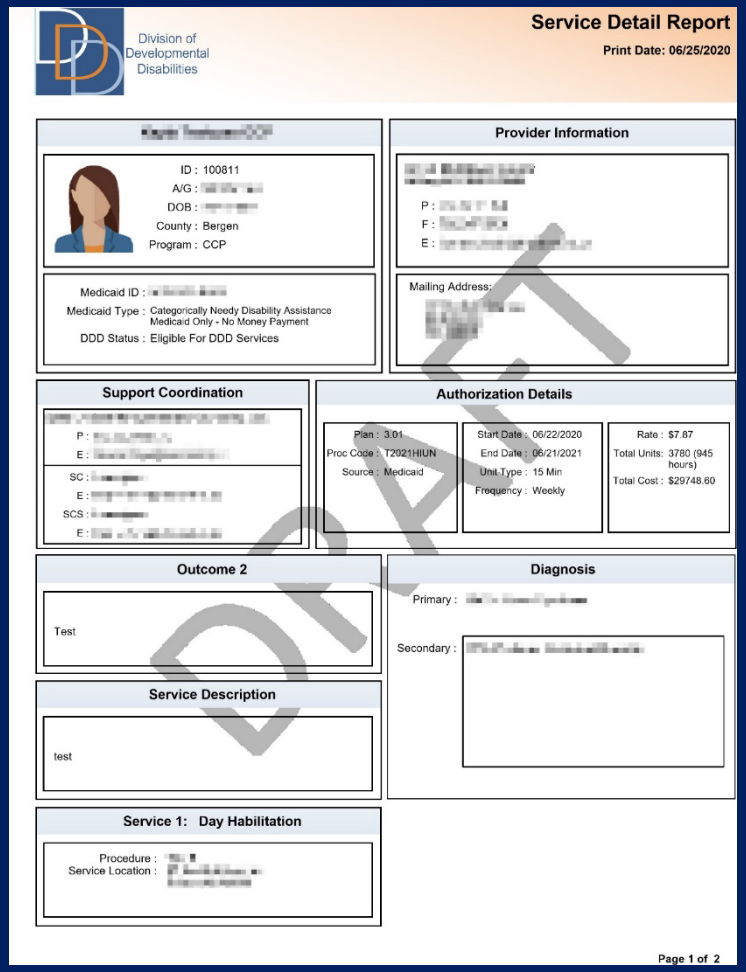
Six Steps Towards Compliance

1. Providing the Correct Service
2. Adhering to Waiver and Regulatory Standards, including hiring practices, properly completing Medicaid application, and training yourself and all staff about their requirements
3. Accurately Documenting the Services
4. Instituting Responsible Billing Practices
5. Properly Supervising all Employees' Provision of Services
6. Establishing a System to Identify and Correct Errors and Omissions concerning Credentialing, Documentation and Billing

Providing the Correct Services

- Service must be “**prior authorized**” in the approved plan
- Service provided must align with the individual’s documented outcomes/goals
- Provider must receive and review a copy of the Service Detail Report
- Provider must adhere to approved service units, unauthorized units will not be paid

Providing the Correct Services



Division of Developmental Disabilities

Service Detail Report

Print Date: 06/25/2020

[redacted]

Provider Information

ID : 100811
A/G : [redacted]
DOB : [redacted]
County : Bergen
Program : CCP

P : [redacted]
F : [redacted]
E : [redacted]

Medicaid ID : [redacted]
Medicaid Type : Categorically Needy Disability Assistance Medicaid Only - No Money Payment
DDD Status : Eligible For DDD Services

Mailing Address: [redacted]

Support Coordination

[redacted]
P : [redacted]
E : [redacted]
SC : [redacted]
E : [redacted]
SCS : [redacted]
E : [redacted]

Authorization Details

Plan : 3.01
Proc Code : T2021HIUN
Source : Medicaid

Start Date : 06/22/2020
End Date : 06/21/2021
Unit Type : 15 Min
Frequency : Weekly

Rate : $7.87
Total Units: 3780 (945 hours)
Total Cost : $29748.60

Outcome 2

Test

Diagnosis

Primary : [redacted]

Secondary : [redacted]

Service Description

test

Service 1: Day Habilitation

Procedure : [redacted]
Service Location : [redacted]

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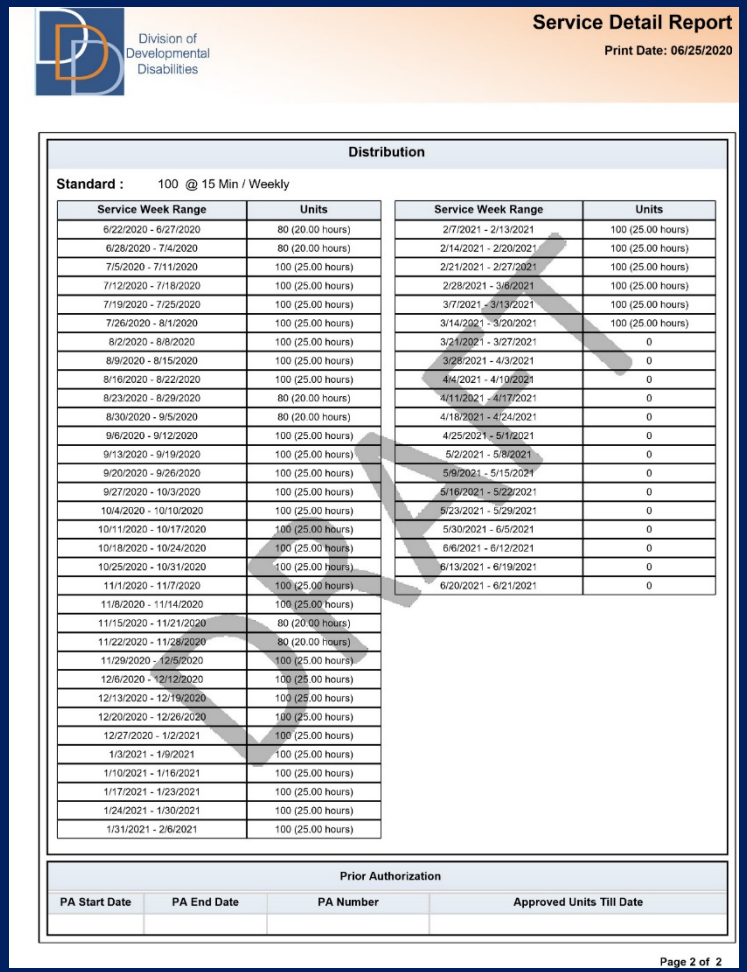

Division of Developmental Disabilities

Service Detail Report

Print Date: 06/25/2020

Distribution

Standard : 100 @ 15 Min / Weekly

Service Week Range	Units
6/22/2020 - 6/27/2020	80 (20.00 hours)
6/28/2020 - 7/4/2020	80 (20.00 hours)
7/5/2020 - 7/11/2020	100 (25.00 hours)
7/12/2020 - 7/18/2020	100 (25.00 hours)
7/19/2020 - 7/25/2020	100 (25.00 hours)
7/26/2020 - 8/1/2020	100 (25.00 hours)
8/2/2020 - 8/8/2020	100 (25.00 hours)
8/9/2020 - 8/15/2020	100 (25.00 hours)
8/16/2020 - 8/22/2020	100 (25.00 hours)
8/23/2020 - 8/29/2020	80 (20.00 hours)
8/30/2020 - 9/5/2020	80 (20.00 hours)
9/6/2020 - 9/12/2020	100 (25.00 hours)
9/13/2020 - 9/19/2020	100 (25.00 hours)
9/20/2020 - 9/26/2020	100 (25.00 hours)
9/27/2020 - 10/3/2020	100 (25.00 hours)
10/4/2020 - 10/10/2020	100 (25.00 hours)
10/11/2020 - 10/17/2020	100 (25.00 hours)
10/18/2020 - 10/24/2020	100 (25.00 hours)
10/25/2020 - 10/31/2020	100 (25.00 hours)
11/1/2020 - 11/7/2020	100 (25.00 hours)
11/8/2020 - 11/14/2020	100 (25.00 hours)
11/15/2020 - 11/21/2020	80 (20.00 hours)
11/22/2020 - 11/28/2020	80 (20.00 hours)
11/29/2020 - 12/5/2020	100 (25.00 hours)
12/6/2020 - 12/12/2020	100 (25.00 hours)
12/13/2020 - 12/19/2020	100 (25.00 hours)
12/20/2020 - 12/26/2020	100 (25.00 hours)
12/27/2020 - 1/2/2021	100 (25.00 hours)
1/3/2021 - 1/9/2021	100 (25.00 hours)
1/10/2021 - 1/16/2021	100 (25.00 hours)
1/17/2021 - 1/23/2021	100 (25.00 hours)
1/24/2021 - 1/30/2021	100 (25.00 hours)
1/31/2021 - 2/6/2021	100 (25.00 hours)
2/7/2021 - 2/13/2021	100 (25.00 hours)
2/14/2021 - 2/20/2021	100 (25.00 hours)
2/21/2021 - 2/27/2021	100 (25.00 hours)
2/28/2021 - 3/6/2021	100 (25.00 hours)
3/7/2021 - 3/13/2021	100 (25.00 hours)
3/14/2021 - 3/20/2021	100 (25.00 hours)
3/21/2021 - 3/27/2021	0
3/28/2021 - 4/3/2021	0
4/4/2021 - 4/10/2021	0
4/11/2021 - 4/17/2021	0
4/18/2021 - 4/24/2021	0
4/25/2021 - 5/1/2021	0
5/2/2021 - 5/8/2021	0
5/9/2021 - 5/15/2021	0
5/16/2021 - 5/22/2021	0
5/23/2021 - 5/29/2021	0
5/30/2021 - 6/5/2021	0
6/6/2021 - 6/12/2021	0
6/13/2021 - 6/19/2021	0
6/20/2021 - 6/21/2021	0

Prior Authorization

PA Start Date	PA End Date	PA Number	Approved Units Till Date

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Waiver and Regulatory Standards

- Provider is responsible to verify with documentation that:
  - Staff is qualified and trained - verify credentials, certification, licenses, establish training schedule
  - Background check performed ensuring that new or potential staff have no disqualifying criminal issues before permitting provision of services
  - Exclusion checks must be performed monthly

Section 6032 Compliance

- Section 6032 of the Federal Deficit Reduction Act requires entities that received payments of $5 million or more in Title XIX funds to assist in preventing and detecting fraud, waste and abuse in federal health care programs by:
  - Establishing written policies for employees, contractors and agents that provide detailed information about federal and state false claims statutes and penalties, and whistleblower protections.
  - Educating employees, contractors and agents on the policies and procedures for detecting and preventing fraud, waste and abuse.
  - Providing information in the employee handbook, if one exists, about federal and state false claims statutes, penalties and whistleblower protections.
- Certification is required annually.
- Please contact Section6032@osc.nj.gov for more information.

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

Medicaid Exclusion List Requirements

MFD Exclusion List Requirements:

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

Medicaid Exclusion List Requirements

- A summary of Federal Exclusion categories are reflected in Appendix I of the Division's Policies and Procedures Manuals.

- Community Care Program Manual: https://www.nj.gov/humanservices/ddd/documents/community-care-program-policy-manual.pdf
- Supports Program Manual: https://www.nj.gov/humanservices/ddd/documents/supports-program-policy-manual.pdf

Accurately Documenting Services

Documentation requirements for DDD Medicaid Waiver Providers

- Documentation requirements arise from a variety of sources
  - Statutes (State and Federal)
  - State Medicaid Regulations and Newsletters
  - State Professional Board Regulations
  - Federal Regulations
  - CMS Guidelines and Policies
  - Community Care Program and Supports Program Manuals
  - Procedure (Billing) Codes
- **Documentation should occur at the same time as the services rendered.**
- **It is the provider's responsibility to know and comply with documentation requirements.**

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

- 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 ten years from the date the service was rendered;
  - To timely furnish information about such services as requested by regulatory agencies, including the Medicaid Fraud Division and DDD compliance units;
  - 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 Requirements – Forms and Formats

- 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 must fully record the services provided and include notes about what occurred.
- Accurate notes of services are important both for continuity of care by other providers and to properly support that the services billed were rendered.
- Please note: Certain services have DDD mandated forms;
- https://www.nj.gov/humanservices/ddd/documents/community-care-program-policy-manual.pdf
  - Appendix D

Documentation

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

- Individual's name
- Date of service
- Signature of person authoring the note
- Signature of supervisor if required

Record must reflect all elements for which provider bills

- Should be done at the time services are rendered, or as close to that as possible
- Time based procedure codes require documentation of time

If Using Handwritten Records

- Content and signature in notes must be legible

Documentation

Notes MUST:

- Align with the service 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

Documentation

Notes MUST Continued:

- Be included on DDD's mandatory service documentation for the following service areas:
    - Community Based Supports,
    - Individual Supports (15 minute increments only)
    - Community Inclusion Services
    - Day Habilitation
    - Prevocational Training
- Providers using an electronic health record (EHR) or other electronic system comply if all information required in these mandatory documents is included and individualized for the recipient and underlying documentation can be produced to support services rendered during an audit.

Documentation

Notes CANNOT:

- Be completed by a staff person not connected to the service provision
- Be duplicative or generic in nature or
- Be written by one staff person for all service recipients aligned with a provider

Documentation

Records/documentation must accurately reflect the services that were rendered.

Documentation should occur at the same time as services rendered.

Don’t shortchange yourself...

If it’s not documented or not documented correctly, it wasn’t done.

Medicaid will not pay you for undocumented or improperly documented services.

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:
  - Division of Developmental Disabilities Procedural (DDD) codes
  - If “prior authorization” is required, the Service Detail Report for that service must support its position

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, and the billing entity.

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

Third Party Liability

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

- 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 of Third Party Liability (TPL) are Medicare, commercial health insurance and Tricare.
- Medicaid benefits are last-payment benefits. All TPL, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid beneficiary.
- If, at the time the provider's claim is filed, third party benefits are not available to pay the beneficiary's medical expenses at the time the provider's claim is filed, then the Division will pay the full amount allowed under its payment schedule and seek post-payment recovery in accordance with 42 CFR 433.139(c), (d)(2), and (d)(3).

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.

Consequences

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

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.

Examples of Medicaid Fraud

N.J.S.A. 30-4D-17

The following are examples of Medicaid violations. These are not inclusive. See the applicable statute N.J.S.A. 30:4D-17.1 and regulation N.J.A.C. 10:49-11.1.“

- It is a violation of State law to knowingly and willfully make or cause to be made any false statement in a claim.
- It is a violation of State law to over bill Medicaid for services provided or services that were not received.
- It is a violation of State law 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.

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 as 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 by DDD for the client by the provider, that fail to meet specific Waiver criteria or credential-related requirements, if applicable.

Waste and Abuse

Professional Due Diligence

Business practices that result in **waste and abuse c**an rise to the level of f**raud:**

- Providing unauthorized service
- Using unqualified / untrained staff
- Inaccurate / incomplete documentation of service
- Submitting unsubstantiated billing
- Insufficient internal checks and balances

Criminal Health Care Claims Fraud

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

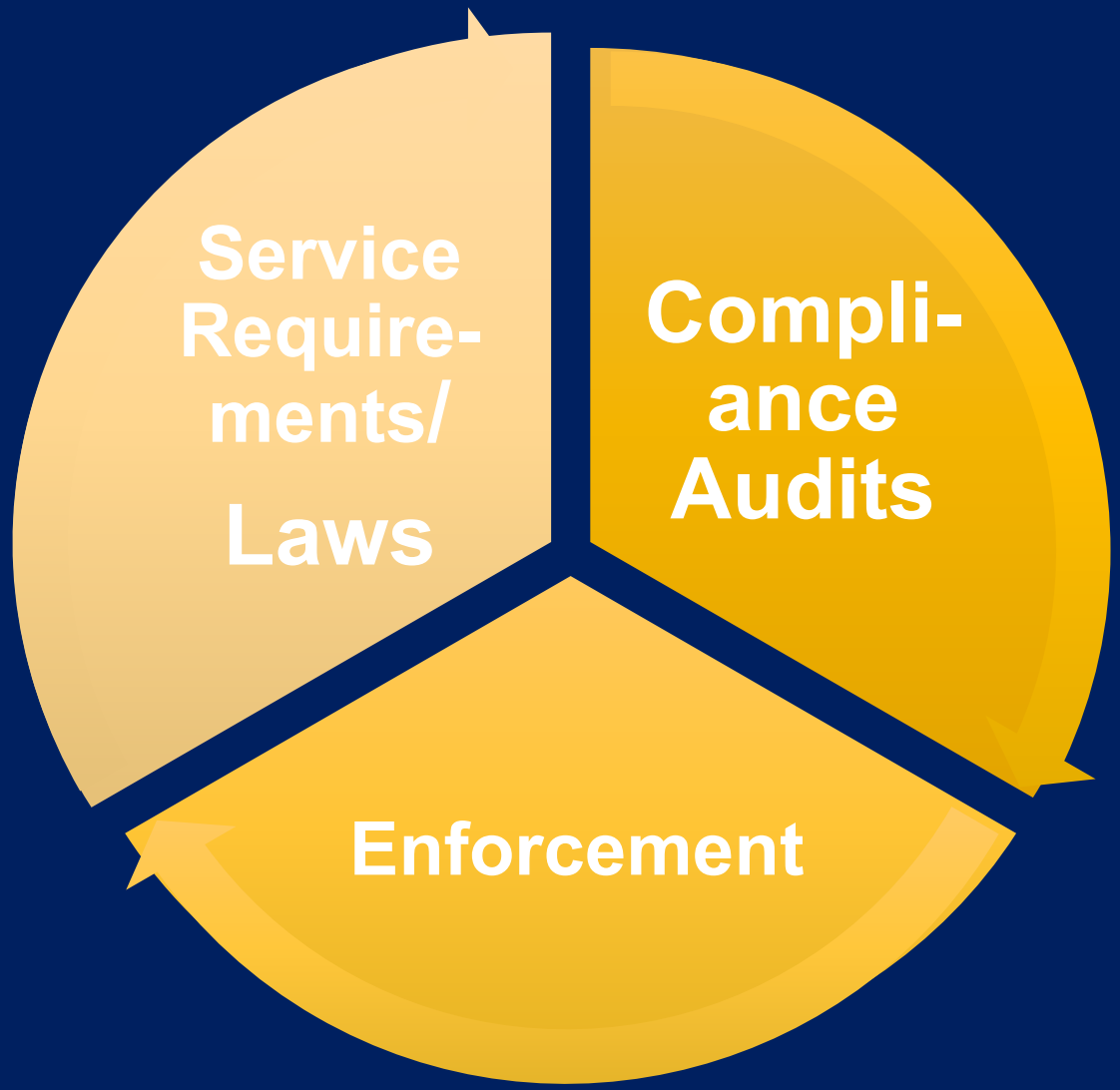
- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject 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

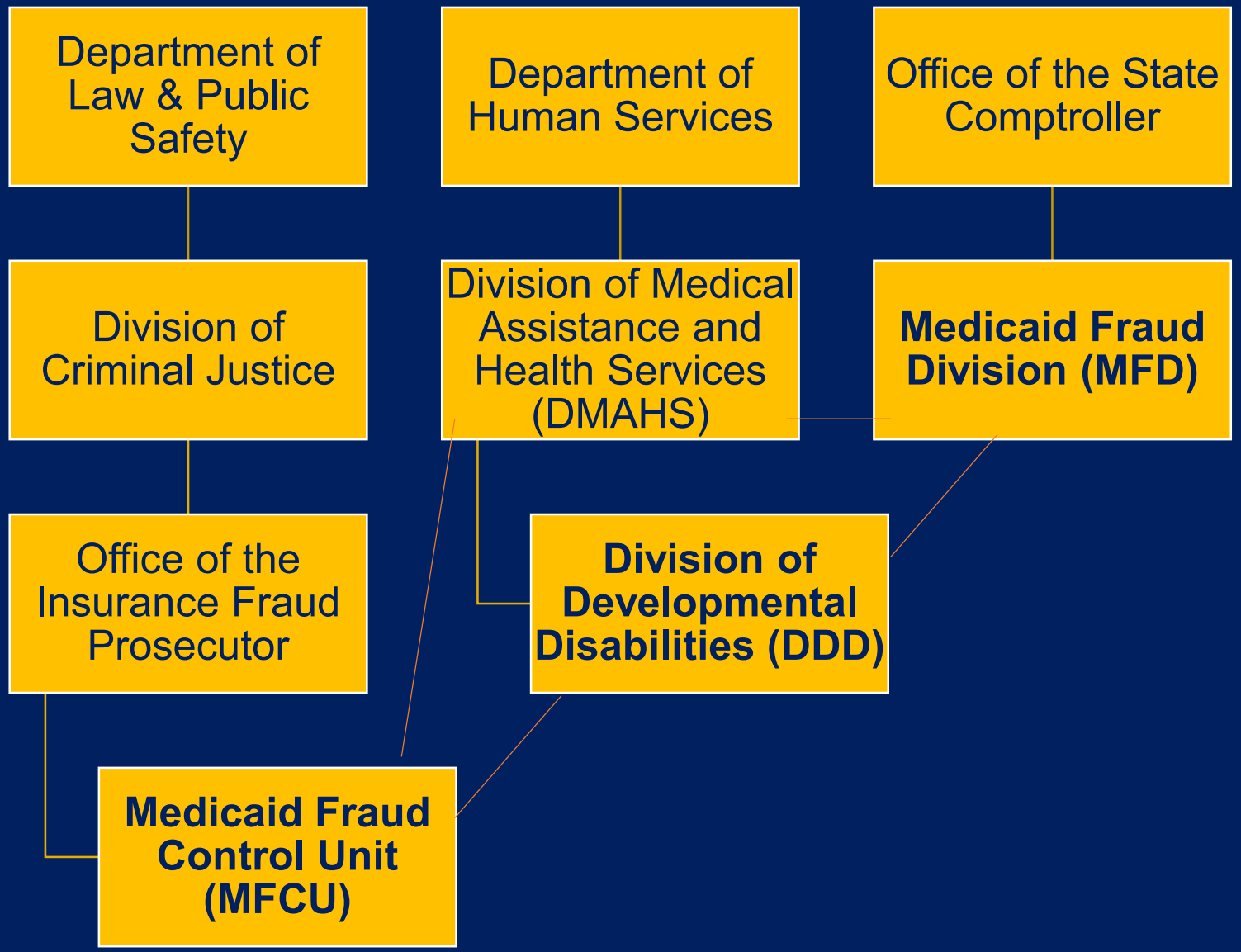
Did you know…

- 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.

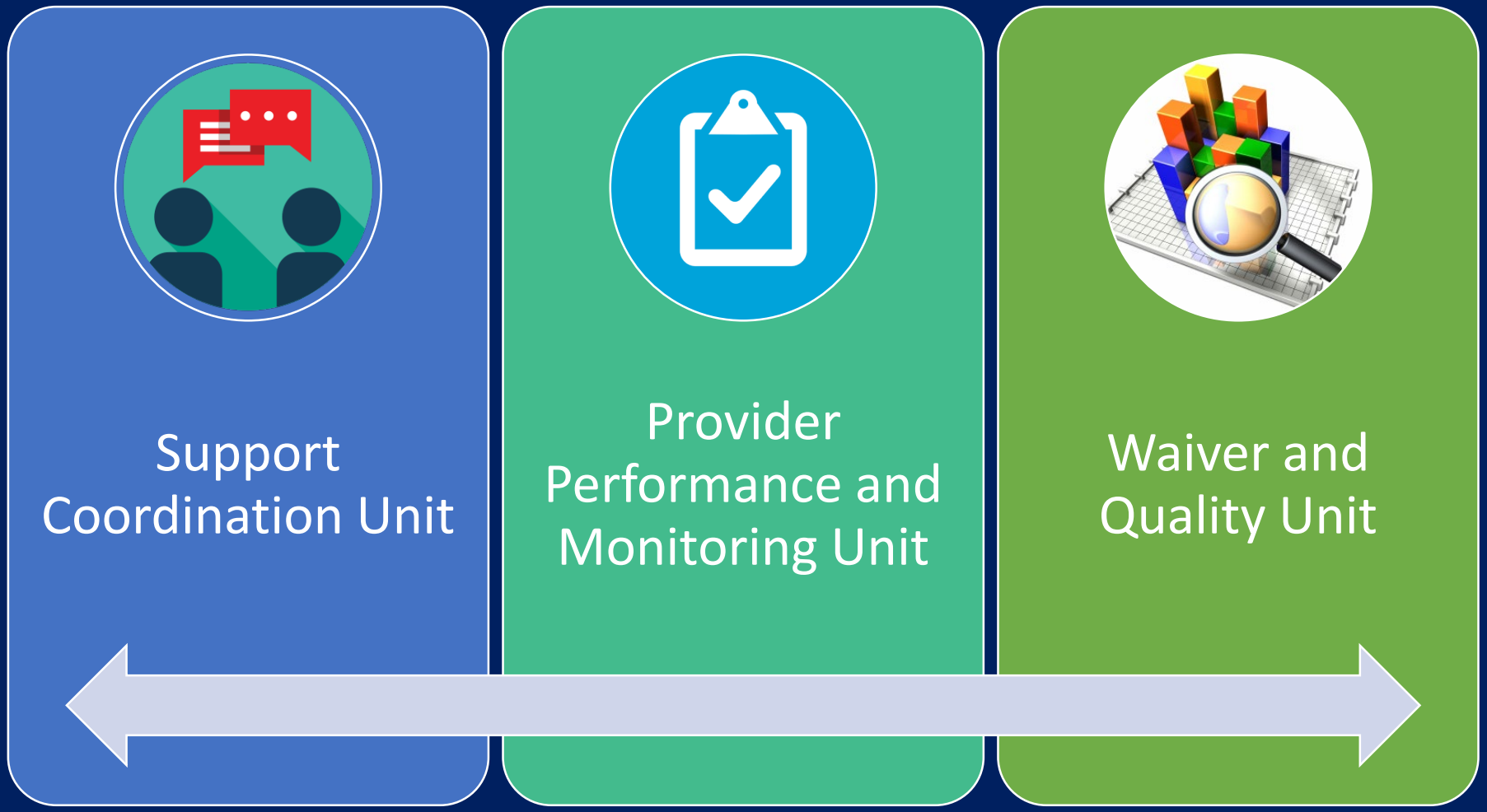
What External Oversight of DDD Providers is in Place?



New Jersey Medicaid Administration and Oversight



Quality Assurance and Monitoring Reviews of DDD/Medicaid Services



Quality Assurance and Monitoring Review Categories

- Personnel Reviews
  - Staff Qualification and Training
- Individual Record Reviews
  - Documentation & Reporting Requirements
- Facility Review (as applicable)
  - Physical Site Inspection
    - HCBS Setting Requirements
  - Emergency Requirements
    - Policies & Procedures
    - Emergency Drills
  - Vehicle Inspection
- Medication Review (as applicable)
  - Administration (MARs)
  - Storage (Onsite, Offsite)

Personnel Record Review Example

1	Employee Name:				Agency Name:					
2	Services rendered by Employee: ☐CBS ☐CIS ☐IS ☐R				Agency Address:	Reviewer's Name:				
3	Date of Hire:				Agency NPI #:	Date of Review:				
	Standard Category	Manual Section	CCP Manual	Service Deliverable	Work Instruction	Yes	No	N/A	ard Weigh	Comments
5	Staff Qualifications	17.5.5.2 (CBS) 17.6.5.2 (CIS) 17.16.5.2(R)	17.5.5.2 (CIS) 17.3.6.2 (IS) 17.16.5.2 (R)	Verification of passing drug test as per Steven Komnino's Law prior to hire	Documentation of drug test must be available for any DSP hired after 6/15/18.	☐	☐	☐	C	
6				Documentation of completed Fingerprint within 10 working days of hire (Employees hired prior to 2002= NA)	Evidenced by fingerprint receipt or hard copy of fingerprinting record.	☐	☐	☐	C	
7				Documentation of Fingerprint results within 6 months of hire date (Employees hired prior to 2002= NA)	Documentation of Hard copy of fingerprint results, State and Feds. See example.	☐	☐	☐	C	
8				Documentation of ongoing Criminal History Record Inquiries (every 2 years)	Verification that archive report (FARA) was conducted every 2 years post original date of Fingerprint record. Employees w/ less than 2 years employment will be "NA".	☐	☐	☐	C	
9				Verification of Central Registry check at time of hire.	Documentation may vary, this may be included on the New Hire Checklist. If unclear, ask agency to describe process and show evidence of its implementation.	☐	☐	☐	C	
10				Documentation of Child Abuse Record Information (CARI) background check (Employees hired prior to July 16, 2018 = NA) at time of hire and annually thereafter.	Documentation of CARI results are required to be printed and retained in the employee personnel file. CARI check is to be completed w/in 10 days of hire w/results processed w/in 30 days of hire.	☐	☐	☐	C	
11				Documentation of minimum of 18 years old (i.e. Driver's license, non-drivers ID, passport or birth certificate)	Copy of valid driver's license, non-driver ID, passport or birth certificate	☐	☐	☐	C	
12				Copy of valid driver's license (if driving individuals)	Copy of valid driver's license must be available to staff who drive individuals served, otherwise answer will be "NA".	☐	☐	☐	C	
13				Record of current Driver's abstract (if driving individuals)	Current Driver's abstract w/ no more than 5 points, if more than 5 pts answer is "NO". ("Current" is defined by agency policy) Answer "NA" if employee does not drive individuals.	☐	☐	☐	C	
14				Verification of Federal Exclusion Check at time of hire and annually thereafter.	This is a debarment list from rendering Federally funded Medicaid services. Documentation may vary, this may be included on the New Hire Checklist. If unclear, ask agency to describe process and	☐	☐	☐	C	

About the Medicaid Fraud Division

The New Jersey "Medicaid Program Integrity and Protection Act", C.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), which created the Medicaid Fraud Division (MFD).

About the Medicaid Fraud Division

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

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.

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 property owned by a provider/owner of business
- MFD may seek a Withholding of future Medicaid payments until the overpayment is satisfied

Self-Disclosure

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://www.nj.gov/comptroller/divisions/medicaid/disclosure/

- 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.

Medicaid Fraud Control Unit (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud Prosecutor (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

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.

Medicaid Fraud

Bottom line:

Ignorance of the law excuses no one.

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

Questions? Please contact us!

Division of Developmental Disabilities

Email: DDD.FeeForService@dhs.nj.gov

Website: https://www.state.nj.us/humanservices/ddd/home/index.html

Medicaid Fraud Division

Email: provider-education@osc.nj.gov

Website: https://www.nj.gov/comptroller/divisions/medicaid/

Medicaid Fraud Control Unit

Email: NJMFCU@njdcj.org

Website: https://www.nj.gov/oag/medicaidfraud/

Thank you for your attention!

New Jersey Office of the State Comptroller
Division of Developmental Disabilities