Medicaid Fraud Division

Useful Tools for a Compliant Medicaid Provider

October 4, 2019

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Goals For Today

To help you better understand:

- The Medicaid regulatory framework
- Medicaid documentation requirements
- 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.

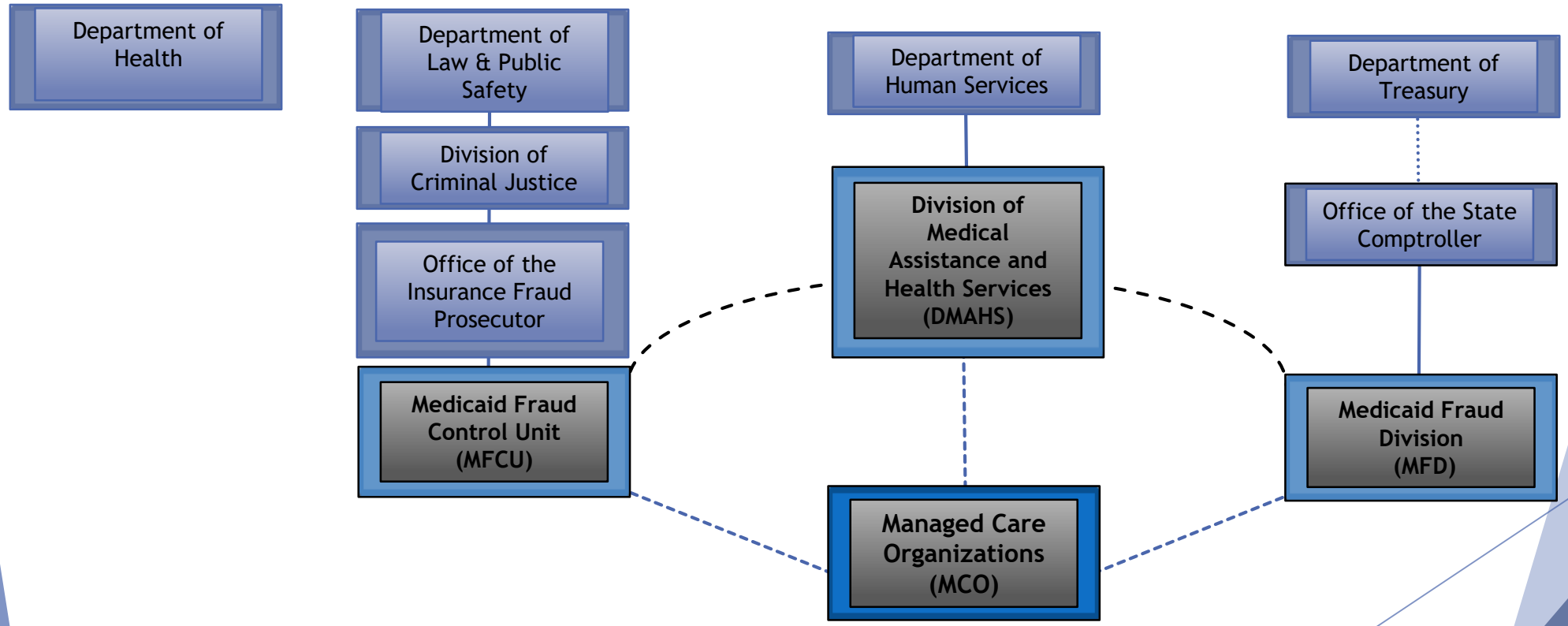
Medicaid Managed Care Contract

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.

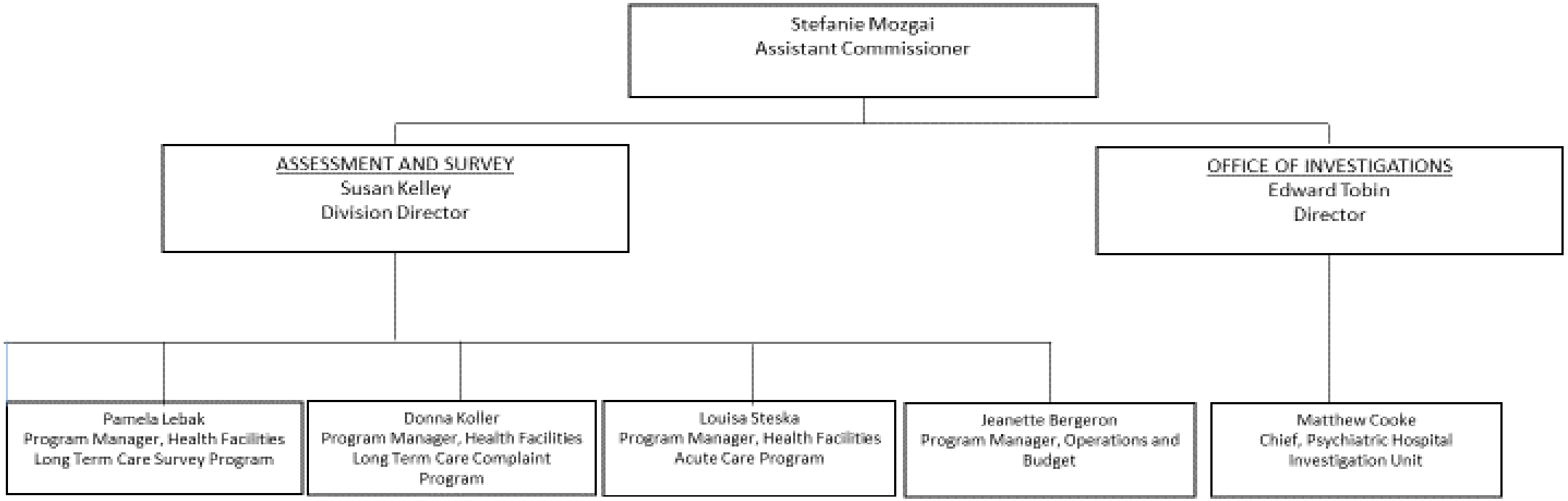
Administration & Oversight

The Medicaid program in New Jersey is administered and/or overseen by



HEATLH FACILITY SURVEY AND FIELD OPERATIONS

Office of the Assistant Commissioner



Who, what, where, when, why

- **Who: Federal and/or state regulatory authority of health care facilities that are state licensed and/or have federal certification to participate in the Centers for Medicare/Medicaid program. (Long-term care and Non-long term care providers)**
- **What: Standard surveys, complaint/incident investigations**
- **Where: On-site surveys/investigations and off-site administrative review**
- **When: Surveys as per a schedule and complaints/incidents by triage and prioritization**
- **Why: To determine a facility's compliance with applicable State &/or Federal regulations.**

NJ Health
New Jersey Department of Health

Long-Term Care Providers

- Nursing Homes (NH)
- Assisted Living Residences (ALR)
- Comprehensive Personal Care Homes (CPCH)
- Residential Health Care Facilities owned &/or operated by another licensed health care provider
- Dementia Care Homes (DCH)
- Assisted Living Programs (ALP)
- Adult Medical Day Care
- Pediatric Medical Day Care
- Intermediate Care Facilities with Individuals with Intellectual Disabilities (ICF/IID) – federal only

NJ Health
New Jersey Department of Health

Acute Care Providers

- Acute Care and Specialty Hospitals
- Psych Hospitals - federal only
- Long Term Acute Care Hospitals (LTACHs)
- Ambulatory Surgery Centers (ASCs)
- Dialysis Centers
- Home Health Agencies (HHAs)
- Hospice Agencies
- Outpatient Therapy (OPT)
- Comprehensive Outpatient Rehab Facility (CORF)
- Portable X-Ray
- Ambulatory Care Facilities (MRI, Primary Care etc.)

NJ Health
New Jersey Department of Health

Survey /Investigation Process

- **Observation: tour, staff practices**
- **Interview: Patients/residents, families, visitors, staff including agency personnel, consultants, vendors**
- **Record review: Medical records, committee meeting minutes, facility documentation ie: investigations, logs etc.**

Partnerships & Referrals

- **Federal: CMS**
- **State: Division of Certificate of Need & Licensing (CN&L), Communicable Disease Service (CDS), Long-Term Care Ombudsman(LTCO), NJ Division of Criminal Justice OAG/Medicaid Fraud Unit, DHS – Division of Aging Services**
- **Local: LHD**
- **Licensing Boards**
- **Healthcare providers: Healthcare Associations**

Sources of Documentation Requirements FFS & MCO Requirements

- Documentation requirements can stem from a variety of sources
  - Statutes (State and Federal)
  - State Medicaid Regulations and Newsletters
  - State Professional Board Regulations
  - Federal Regulations
  - CMS Guidelines and Policies
  - MCO Provider Contracts, Manuals, Provider Agreements, Newsletters, etc.
  - Medical Billing Codes
  - Industry-wide Standards
- *It is the provider's responsibility to be knowledgeable of and comply with documentation requirements.*

Upcoming Changes to MCO/Provider Contracts

- In July of 2019, DMAHS and the MCOs revised the MCO/DMAHS contract to standardize certain documentation requirements so they are consistent between FFS and MCO claims.
- MCOs are required to include these documentation requirements in their provider contracts. Providers can expect to see changes to their contracts in the coming months to address this contract requirement.
- Changes will relate to the content of records, length of record retention, etc.
- Keep on the lookout for these changes, because non-compliance could lead to overpayments and recovery demands by MFD and/or the MCOs.

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

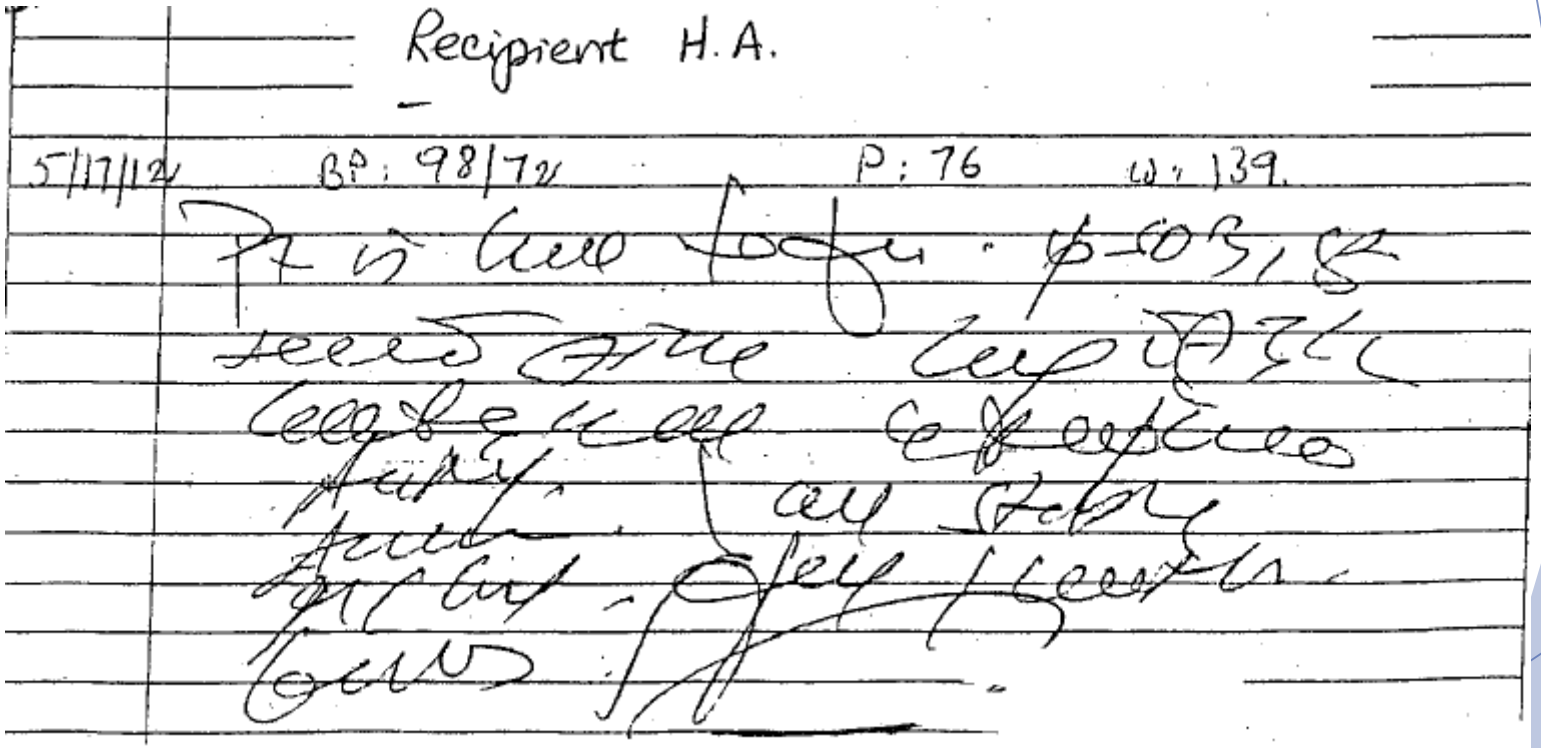
- There are generally two types of medical records, either handwritten or Electronic Health Records (EHR).

- Regardless of the type of record the content must be accurate and complete. It is a record of what occurred and it is 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
  - Time based procedure codes

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

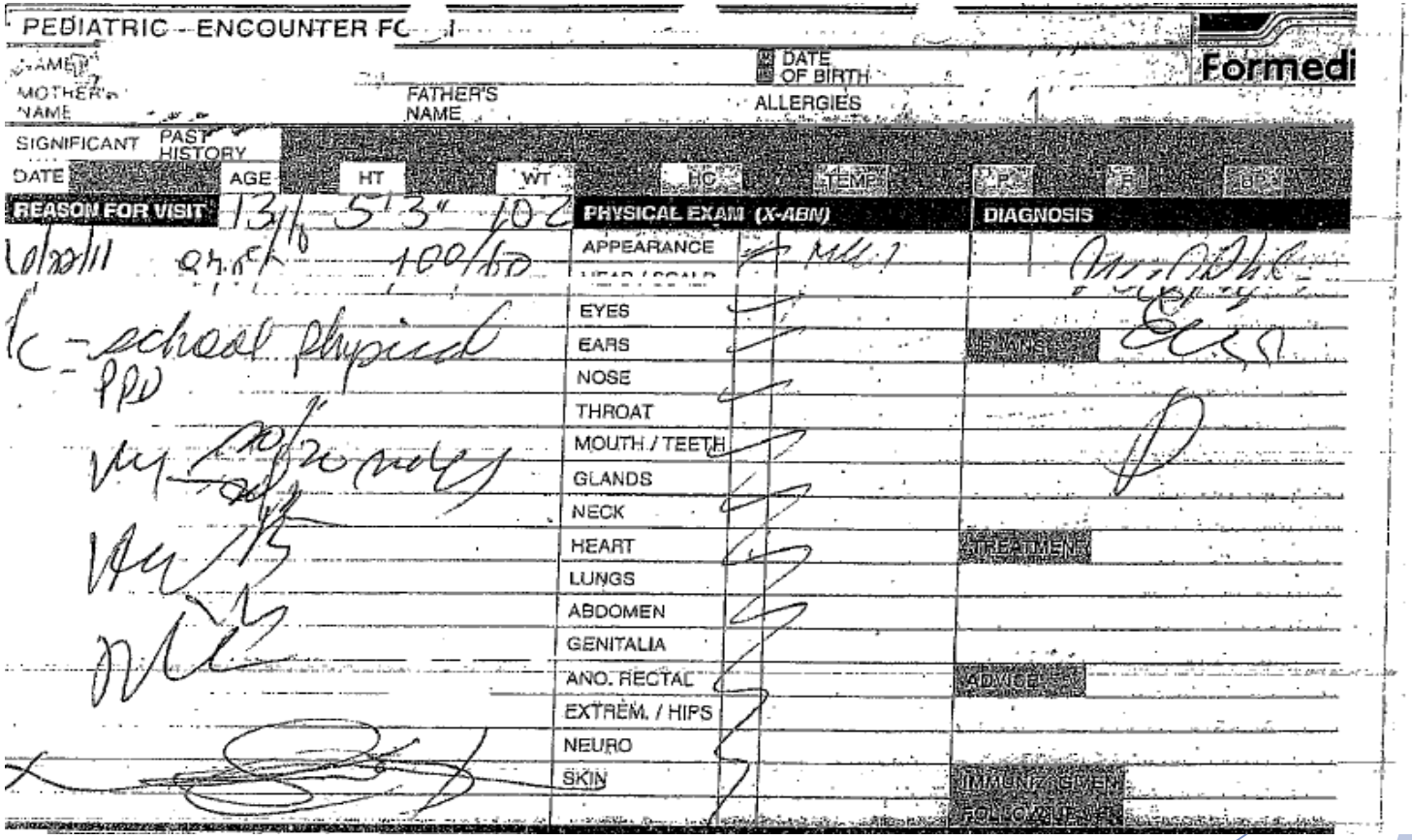
STABLE CONTINUE ALL MEDS AS ORDERED AND FOLLOW UP IN ONE MONTH.

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.

Documentation must be legible


PEDIATRIC – ENCOUNTER FC

Formedi

NAME

MOTHER'S NAME

FATHER'S NAME

DATE OF BIRTH

ALLERGIES

SIGNIFICANT PAST HISTORY

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

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

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.

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!!!

This responsibly is the same for groups, billing, and servicing providers.

Claims Submission Requirements For Providers, Who Are Responsible For All Billing:

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 Definition

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/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.html

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***

Fraud, Waste and Abuse Examples

Physicians

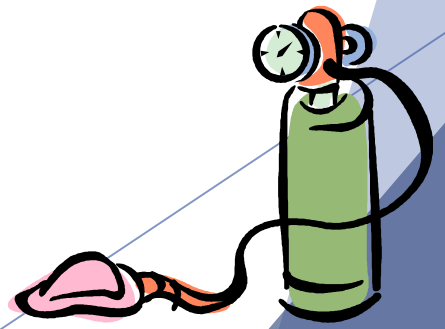
- Bill for patients never seen
- Bill for services never rendered
- Up-coding
  - Bill higher level of service than provided
- Provide services not medically necessary
- Misuse of National Provider Identifier (NPI) Number

Hospitals

- Offering kickbacks to physicians for referring patients
- Up-coding
- Unbundling
  - Billing for procedures separately that should be grouped
- Buying medication or supplies at a discount and billing retail price
- Billing for services never rendered
- Billing for acute admissions when observation was more appropriate

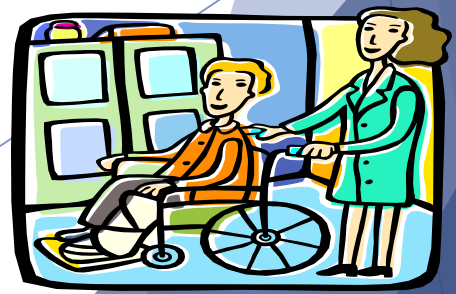
Durable Medical Equipment (DME)

- Billing for new but providing used
- Billing for equipment that was never provided
- Providing kickbacks to providers or recipients to recruit new Medicaid customers
- Providing equipment that does not meet Medicaid regulations
- Dispensing without a legitimate prescription
- Filling refills without a prescription
- Upcoding type of equipment dispensed
- Misrepresenting services provided



Home Healthcare Agencies

- Getting physicians to approve home health care services when they aren't indicated
- Billing for hours that the home health aide wasn't present
- Using staff that isn't properly licensed
- Falsifying patient charts to show that patient shows no improvement and still needs home health services
- Missing 6 month nursing assessments for plan of care



Long Term Care Facilities

- Fail to report death of a recipient
- Billing for patients after they have been discharged
- Assisting recipients in concealing their true financial situation
- Providing services that are not indicated or are excessive
- Billing for equipment that was never purchased or is used
- Permitting vendors to shop services that are already covered by Medicaid

Adult Medical Daycare Centers

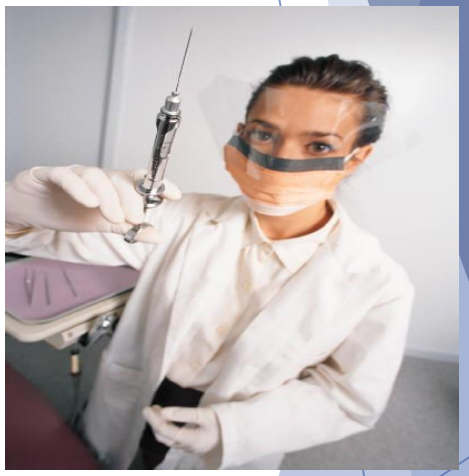
- Billing for services that were never performed
- Not having the appropriate staff present at the facility
- Not providing necessary assistance in activities of daily living
- Offering incentives to recipients to refer patients
- Not documenting medical services actually provided and duration of programs in which the recipient participated

Pharmacies

- Billing for NDCs that were not dispensed
- Over filling prescriptions
- Purchasing prescriptions from indigent patients
- Billing for prescriptions that were never filled
- Accepting cash from Medicaid patients for Scheduled Controlled Dangerous Substances
- Not checking PMP
- Failing to demonstrate purchase of inventory for Medicaid claims.

Labs

- Offering kickbacks to doctors for prescribing certain tests
- Falsifying prescriptions for lab work
- Performing lab work without proper authorization
- Performing tests that were never ordered
- Re-perform tests on the same samples
- Billing for tests performed by another lab



Recipient Fraud

- Falsifying or concealing income or assets to obtain Medicaid or Charity Care fraudulently
- Providing misleading information about medical history and disability
- Recipients allowing others to use their benefit ID cards
- Obtaining narcotics prescriptions under false pretenses and then selling them

Medical Identity Theft

- Popular in organized crime
- Uses tactics similar to other ID thieves with a few additions
  - Potential thieves may stake out doctors office waiting rooms, use obituaries, and access social networking to obtain information necessary to fraudulently bill Medicaid

Misuse of National Provider Identifier (NPI) Number

- Credentialing of providers is required pursuant to NJAC 11:24, Medicaid Contract between NJ DMAHS and MCOs and other requirements.
- Improper/unauthorized use of another physician's NPI number on claim submission is not allowed and violates NJAC 10:49 and NJSA 2C:21 as well as the State of NJ and Federal False Claims Acts.
- Done to "mask" the fact that the rendering physician or nurse practitioner **is not** a Medicaid/MCO approved, credentialed, participating or contracted provider
- Results in claim payment when – if non credentialed servicing practitioner's NPI was used on claim form – claim would have been **denied**
- Such providers may not be licensed, unresolved BME/Licensing sanctions, suspended, debarred, not contracted/participating with MCO, etc.
- Different reimbursement levels between practitioners (i.e. NP's 85% of MD)

Misuse of National Provider Identifier (NPI) Number

FILED
OCTOBER 5, 2011
NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

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STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

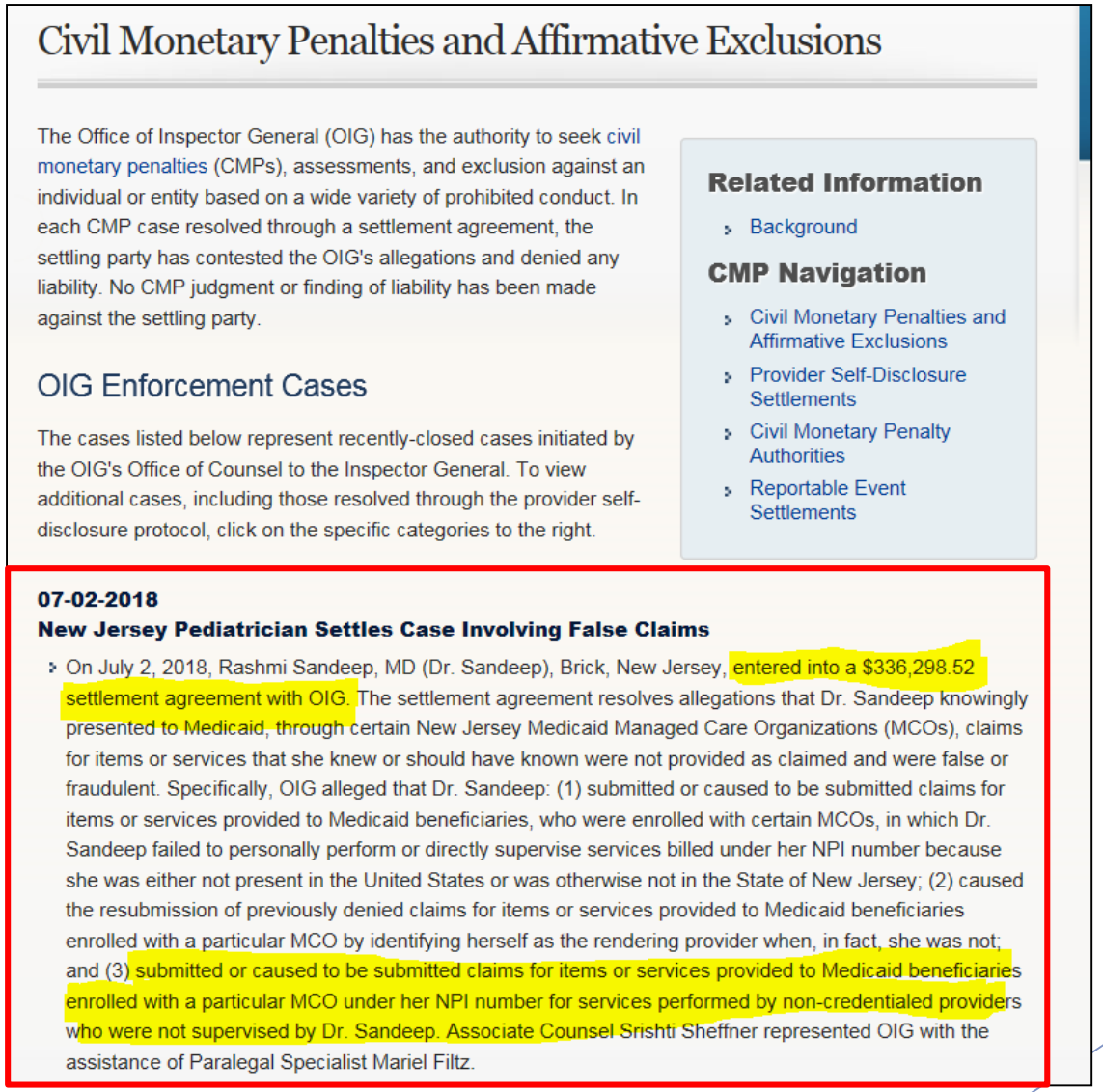
IN THE MATTER OF THE LICENSE OF	:	Administrative Action
	:	
	:	ORDER GRANTING
	:	UNRESTRICTED LICENSURE
	:	
TO PRACTICE MEDICINE AND SURGERY	:	
IN THE STATE OF NEW JERSEY	:	

Following a conviction for three counts of criminal sexual contact in the fourth degree, Dr. license was suspended for five years (commencing July 25, 2006) by Consent Order filed November 2, 2006.

is to have a chaperone present whenever he examines female patients.

Suspended license - Debarred from Medicaid
Chaperone required for female patients

Misuse of National Provider Identifier (NPI) Number



Civil Monetary Penalties and Affirmative Exclusions

The Office of Inspector General (OIG) has the authority to seek civil monetary penalties (CMPs), assessments, and exclusion against an individual or entity based on a wide variety of prohibited conduct. In each CMP case resolved through a settlement agreement, the settling party has contested the OIG's allegations and denied any liability. No CMP judgment or finding of liability has been made against the settling party.

OIG Enforcement Cases

The cases listed below represent recently-closed cases initiated by the OIG's Office of Counsel to the Inspector General. To view additional cases, including those resolved through the provider self-disclosure protocol, click on the specific categories to the right.

Related Information

- Background

CMP Navigation

- Civil Monetary Penalties and Affirmative Exclusions
- Provider Self-Disclosure Settlements
- Civil Monetary Penalty Authorities
- Reportable Event Settlements

07-02-2018

New Jersey Pediatrician Settles Case Involving False Claims

- On July 2, 2018, Rashmi Sandeep, MD (Dr. Sandeep), Brick, New Jersey, entered into a $336,298.52 settlement agreement with OIG. The settlement agreement resolves allegations that Dr. Sandeep knowingly presented to Medicaid, through certain New Jersey Medicaid Managed Care Organizations (MCOs), claims for items or services that she knew or should have known were not provided as claimed and were false or fraudulent. Specifically, OIG alleged that Dr. Sandeep: (1) submitted or caused to be submitted claims for items or services provided to Medicaid beneficiaries, who were enrolled with certain MCOs, in which Dr. Sandeep failed to personally perform or directly supervise services billed under her NPI number because she was either not present in the United States or was otherwise not in the State of New Jersey; (2) caused the resubmission of previously denied claims for items or services provided to Medicaid beneficiaries enrolled with a particular MCO by identifying herself as the rendering provider when, in fact, she was not; and (3) submitted or caused to be submitted claims for items or services provided to Medicaid beneficiaries enrolled with a particular MCO under her NPI number for services performed by non-credentialed providers who were not supervised by Dr. Sandeep. Associate Counsel Srishti Sheffner represented OIG with the assistance of Paralegal Specialist Mariel Filtz.

Third Party Liability

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 program.

It is the provider's responsibility to be aware of a patient's "other" insurance.

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

Third Party Liability

- Medicaid is the payer of ***last*** resort.
- A TPL's potential liability to pay for services ***cannot*** prevent a Medicaid beneficiary from receiving covered services.
- TPL Billing Do's & Don'ts
  - Balance billing – Don't
  - TPL co-payment – Don't
  - TPL payment paid to the beneficiary - Do

MFD Audits and Investigations

Medicaid Fraud Division Audits & Investigations

Review Period

N.J.S.A 2A:14-1.2

- 10 year statute of limitation
- MFD has the capability to review records as far back as 2008

N.J.S.A 30:4D-12

- 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 or MCO contract.
  - Duration of services

Medicaid Fraud Division Audits & Investigations

Relevant Statutes

N.J.A.C. 10:49-9.8

- 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. Pre-Admission Screening (PAS), admission and authorization is required to determine level of care that will be required, clinical and financial eligibility forms.
- 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

- Services not covered by Medicaid if
  - No medical necessity
  - No prior authorization
  - Records inadequate and illegible
  - Billing, prescribing, ordering or servicing 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.

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

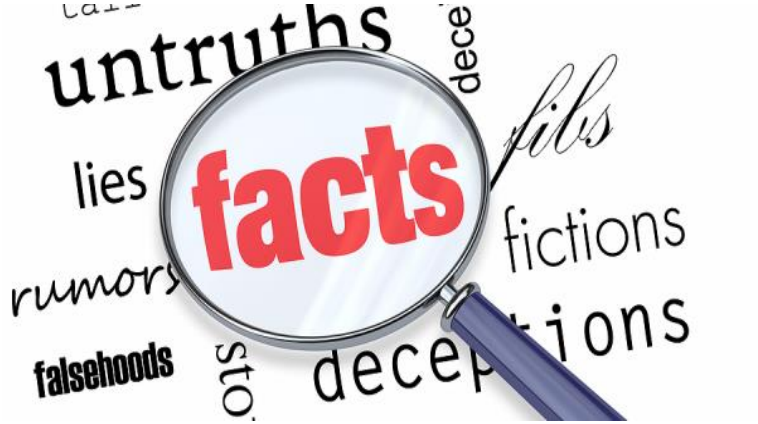
- Punishable by up to 5 years in state prison
- Mandatory penalty up to $25,000 for each violation
- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Restitution/Recovery of overpayments

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

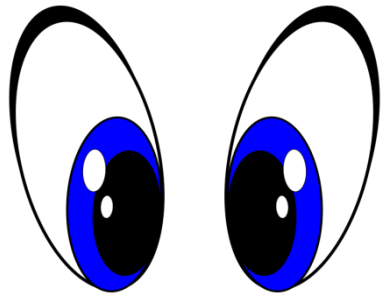
Did you know…

- 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

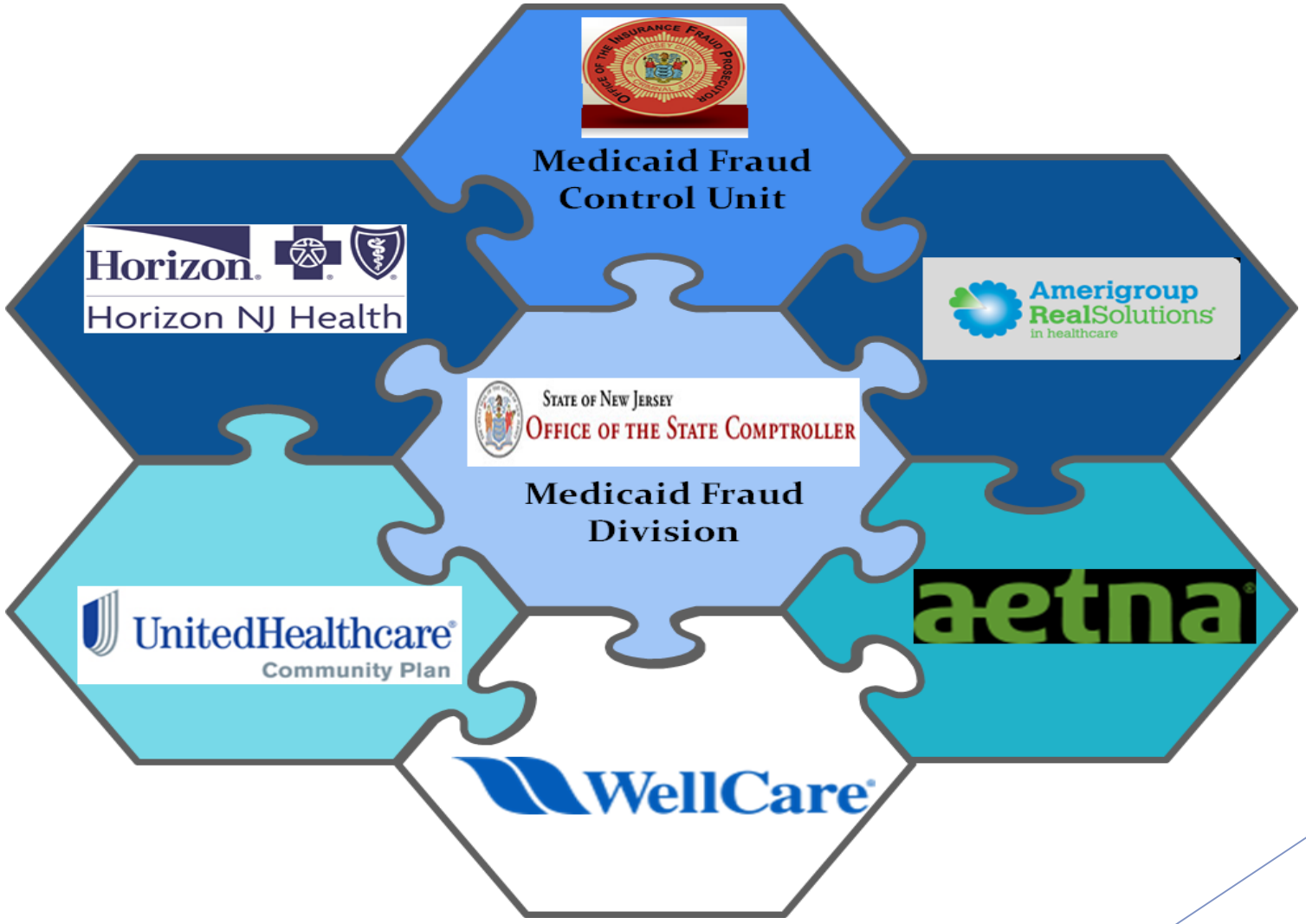
- Empowers people to file civil suit against individuals and companies that defraud the federal, state or local government.
- A person filing suit might be eligible for up to a 30 percent share of the recovery.
- A person filing suit might be protected from being fired or retaliated against by their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

Excluded, Suspended or Disqualified 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
- www.nj.gov/comptroller/divisions/medicaid/disclosure

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 $11,181 to $22,363 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 $11,181 and $22,363
  - File a Certificate of Debt on real property owned
  - Seek a Withholding of future Medicaid payments until the overpayment is satisfied

Questions

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