UTAH OFFICE OF INSPECTOR GENERAL – MEDICAID SERVICES 2017 ANNUAL REPORT

11/1/2017

Inspector General – Medicaid Services

The Utah Office of Inspector General of Medicaid Services was established on July 1, 2011. The primary goal of the Office is to safeguard taxpayer assets through the reduction of fraud, waste, and abuse.

Utah Office of
Inspector General

Gene Cottrell
Inspector General

Greetings,

It is my pleasure to present the Utah Office of Inspector General's (UOIG) State Fiscal Year 2017 Annual Report outlining the Office's sixth year of service to the taxpayer's of Utah. I am extremely proud of the tireless work performed by the consummate group of professionals that comprise this office. SFY 2017 was the second year since my appointment as the Inspector General of Medicaid Services and I could not have asked for a more professional team.

Over the past year this team of professionals has reviewed thousands of Medicaid claims, uncovered and referred fraud, identified more than $6 million in inappropriately paid funds, made policy recommendations to Utah Department of Health management and conducted training at all levels of Medicaid participation. All of these tasks were performed while restructuring the Office, certifying new employees and documenting processes. Indeed, SFY 2017 was one of the busiest since the creation of the Office.

The following report will outline some of the key initiatives undertaken by the Office over the past year including reviews, investigations, inspections, audits, evaluations and self-audits. Additionally the report provides information on the Office's efforts to provide training to the provider community on common billing errors, identification of fraud, waste and abuse, and proper reporting procedures.

We continue to improve in all areas of our responsibilities. Medicaid Program Integrity is a highly regulated area of health care that requires uniquely qualified employees to conduct the type of work our Office performs. We continuously seek to improve our employee's skillsets through various certifications and recertification's such as Certified Fraud Examiners (CFE) and Certified Inspector General Auditors (CIGA) and Certified Inspector General Investigators (CIGI), as well as maintaining our Nurses' certifications.

The Office will continue to improve how it does business over the next few years and will expand into areas of Medicaid that have not previously been looked at in detail. During a 2016 Center's for Medicare and Medicaid Services Survey of the Utah Medicaid Program CMS Auditors identified areas for improvement for Audits of the Managed Care Organizations in Utah. The Office opened a number of audits into Managed Care and will continue to expand, through additional audits, into the Managed Care arena during SFY 2018.

It is a pleasure for me and my staff to continue our work on behalf of the Taxpayers of Utah. We appreciate the support of the Governor's Office and our State Legislators and we look forward to our continued partnerships with them as we continue making Utah's Medicaid program the best in the entire country.

Sincerely,

Gene D. Cottrell
Inspector General
Office of Inspector General of Medicaid Services

DRIVING A MORE EFFICIENT STATE GOVERNMENT

2017 ANNUAL REPORT

Contents

Introduction

Utah Office of Inspector General of Medicaid Services Mission Statement

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

Creation and Statutory Authority

The Utah Office of Inspector General (UOIG) of Medicaid Services fulfills the federal program integrity requirement to ensure compliance, efficiency and accountability within the State Medicaid program by detecting and preventing fraud, waste, and abuse under 42 CFR 455 and 456. Prior to 2011, the program integrity function was housed within the Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF). The UOIG was established during the 2011 General Session of the Utah State Legislature through House Bill 84. The independent nature of the UOIG allows the maximization for recovery of improper Medicaid payments and creates a more efficient and accountable structure for identifying fraud, waste and abuse within the Medicaid program.

In order to create the UOIG the Bureau of Program Integrity and the Office of Internal Audit were dissolved and those resources were used to create the Office. The Office of Internal Audit has since been reconstituted to conduct internal audit functions outside of the scope of the UOIG.

Pursuant to Utah Code § 63A-13-202, the UOIG shall: (1) Inspect and monitor (a) the use and expenditure of federal and state funds, (b) the provision of health benefits and other services, (c) implementation of, and compliance with, state and federal requirements, and (d) records and recordkeeping procedures, in relation to the Medicaid program. (2) Receive reports of potential fraud, waste or abuse in the state Medicaid program. (3) Investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program. (4) Consult with the Centers for Medicaid and Medicare Services and other states to determine and implement best practices for (a) educating and communicating with health care professionals and providers about program and audit policies and procedures, (b) discovering and eliminating fraud, waste, and abuse of Medicaid funds, (c) differentiating between honest mistakes and intentional errors, or fraud, waste, and abuse, if the office enters into settlement negotiations with the provider or health care professional. (5) Obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program. (6) Work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds. (7) Audit, inspect, and evaluate the functioning of the division for the purpose of making recommendations to the

Legislature and the department to ensure that the state Medicaid program is managed (a) in the most efficient and cost-effective manner possible; and (b) in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services. (8) Regularly advise the department and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible. (9) Refer potential criminal conduct, relating to Medicaid funds or the state Medicaid program to the fraud unit. (10) Refer potential criminal conduct, including relevant data from the controlled substance database, relating to Medicaid fraud, to law enforcement in accordance with Title 58, Chapter 37f, Controlled Substance Database Act. (11) Determine ways to (a) identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program, and (b) balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program. (12) Recover improperly paid Medicaid funds. (13) Track recovery of Medicaid funds by the State. (14) In accordance with § 63A-13-502 (a) report on the actions and findings of the Inspector General, and (b) make recommendations to the Legislature and the Governor. (15) Provide training to (a) agencies and employees on identifying potential fraud, waste, or abuse of Medicaid funds, and (b) health care professionals and providers on program and audit policies and compliance. (16) Develop and implement principles and standards for fulfillment of the duties of the inspector general, based on principles and standards used by (a) the Federal Offices of Inspector General, (b) the Association of Inspectors General, and (c) the United States Government Accountability Office.

The Office seeks to fulfill all of its duties and responsibilities through cooperative effort with State and Federal authorities as well as the Utah Department of Health and the provider community.

Organizational Structure

The UOIG is led by the Inspector General, Gene Cottrell, who is assisted by the Deputy Inspector General, Nate Johansen. They are supported by the Executive Assistant, Joan O'Neil.

The Office is organized into four teams who are capable of working independently of each other on specific projects or working collaboratively on projects that require a more multi-functional team approach (see figure 1). The teams are:

Program Integrity/Perm Team (PI): This team is primarily responsible for fulfilling tasks associated with the contractual relationship between the UOIG and DMHF. They focus on post payment medical reviews to ensure payments were billed and paid appropriately. This team is managed by Andrew Hill and is comprised of three Nurse Investigators and one PERM/Eligibility Specialist.

Special Investigations and Inspections Unit (SIIU): This team is responsible for conducting preliminary investigations of suspected fraud, as well as full investigations into the causes and effects of waste and abuse. Additionally, this team conducts on-sight

inspections of providers to ensure the needs of Medicaid clients are receiving adequate care. This team also recommends and oversees the self-audit function. The SIIU is managed by John Slade and is comprised of four Nurse Investigators and two non-medical Investigators.

Audit Team: This team is responsible for conducting evaluations and audits of Medicaid policies and processes where the potential for risk exists and across the full spectrum of Medicaid services. The Audit Team is managed by Neil Erikson who leads five auditors.

Mission Support Team: The Mission Support Team is managed by the Deputy Inspector General and is comprised of specialists in four areas that are essential to the success of the three other teams. They are:

1. Policy and Training Coordinator: The current Policy and Training Coordinator is Steven Anthony. Steve provides policy research that supports the other sections in their work. He is also responsible for coordinating all training activities, internal and external, for the Office. In addition, Steve serves as the UOIG Public Information Officer.
2. Data Scientist: Mylitta Barrett is the UOIG Data Scientist. She is responsible for gathering and analyzing data in support of all UOIG engagements.
3. Program Specialist: The Program Specialist, Chelsey Daniel, coordinates all settlement conferences and administrative hearings within the Office. In addition the Program Specialist receives and posts recovered Medicaid funds that result from work conducted by the PI, SIIU, and Audit teams.
4. Office Specialist: The Office Specialist, Judy Xiong, is responsible for requesting, receiving, uploading and organization of all records requested by the UOIG.

In addition, the Office employees one part-time Administrative Law Judge, Lisa Watts Baskin. Judge Baskin is responsible for impartially adjudicating all agency actions that come before her. The Office is careful to provide hearing rights on any action that it takes against a provider.

The Office receives legal support through an assigned Assistant Attorney General, Lana Taylor who assists with questions of law and provides hearing support on a regular basis.

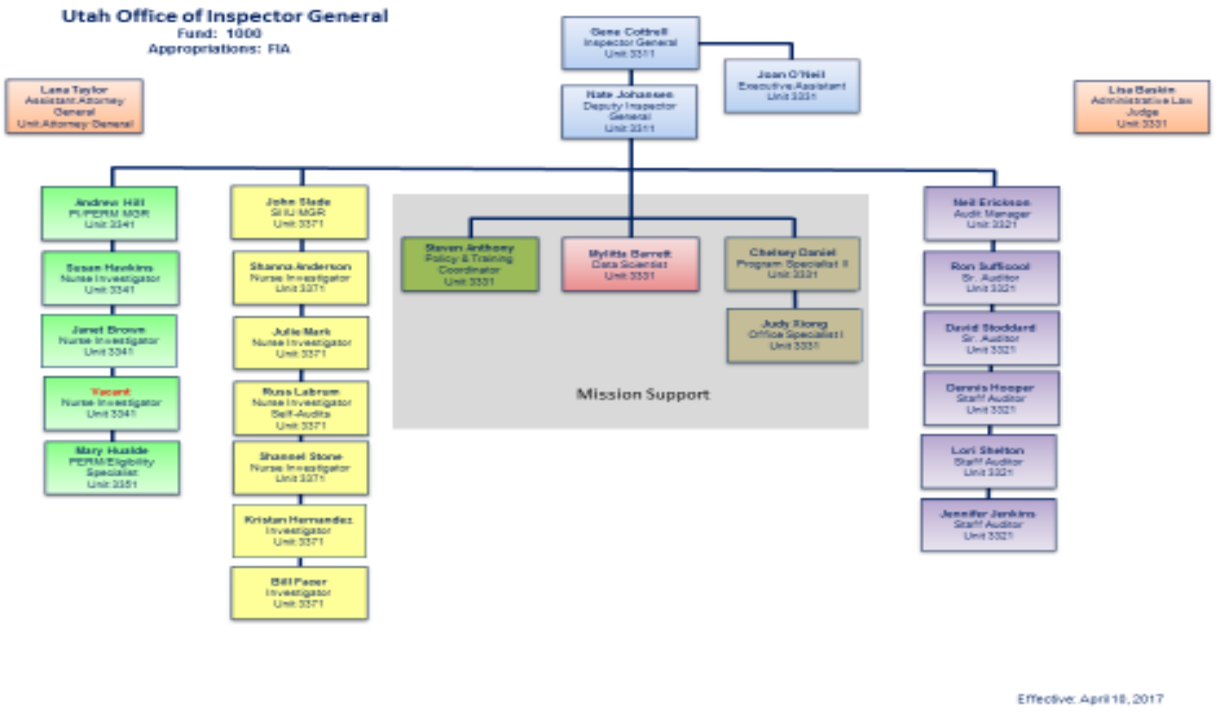

Figure 1- UOIG Organizational Chart

Funding the UOIG

The Utah Office of Inspector General is funded through State funds that act as seed money for a federal match that is possible because of the Program Integrity (PI) role the UOIG performs. The funding sources for SFY 2017 are outlined in table 1.

SFY 2017 UOIG Funding Sources

Source	*Source Document*	*Amount*
State	General Fund (SB006)	$1,122,500.00
State	Pass Thru (SB008)	$1,400.00
Federal	Transfer XIX Admin (SB006)	$2,325,200.00
State/Federal	Previous Year Balance Forward	$386,700.00
	Total	$3,835,800.00

Table 1- SFY 2017 UOIG Funding Sources

Expenditures by the UOIG are paid from both Federal and State funds. All expenditures are covered by a match rate which is based upon the function performed. The most common rates are 50/50 (federal/state) and 75/25 (federal/state). However, some functions, such as Health Information Technology (HIT) auditing and PRISM development, result in a 90/10 (federal/state) match. During SFY 2017 the results of this match rate method of cost allocation was that 57.6% ($1,550,211.38) of the Office's total expenditure was covered by federal funds with the remaining $1,139,781.88 coming from State funds.

Medical Reviews and Investigations

During SFY 2017 the Office reviewed 8287 claims that covered 10 of the 95 provider types and resulted in 615 Notices of Recovery. The review of those claims resulted in the recovery of $3,078,501 in inappropriately paid Medicaid funds. The recovery methods included cash collection, credit adjustments and the rebilling of claims by the provider. The Medicaid Recovery Audit Contractor (RAC) recovered an additional $422,099 while it was still under contractual control of the UOIG. Audits of Health Information Technology (HIT) systems recovered $2,835,831.

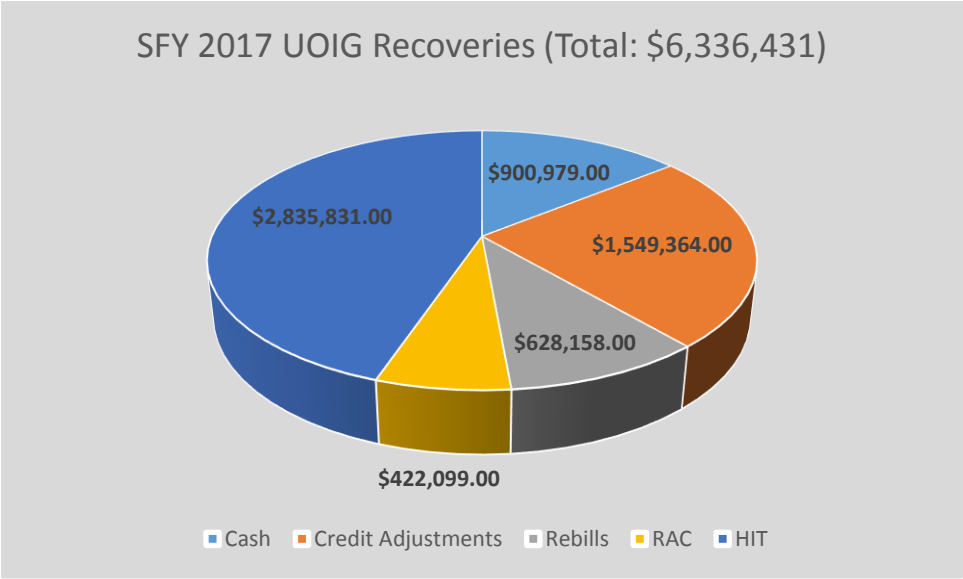

Figure 2- SFY 2017 UOIG Recoveries

SFY 2017 Case of Interest

DRG 790-Neonates with Extreme Prematurity, or RDS

Up-coding with the ICD-10 diagnosis code of P22.0-Respiratory Distress Syndrome, results in significantly higher reimbursement for inpatient newborn claims. The average length of stay for DRG 790 is 16-32 days, however in 2016, OIG identified an increasing trend in newborn claims billed with DRG 790, with lengths of stay from 1-10 days. Medical records for these claims identifies babies born at 36 or greater gestational weeks at birth, with difficult transitioning following birth requiring CPAP and/or oxygen for a short period of time. Chest X-rays commonly report: retained lung fluid; wet lungs; TTN; increased lung volume with flat diaphragms. Respiratory symptoms typically resolve within 24-48 hours and the baby will often discharge to home with the mother. It is common that chest X-rays and repeat arterial blood gases (ABG's) are not even ordered. Many attending providers are using the terms "*respiratory distress*" and "RDS" interchangeably throughout the medical record and the claim is subsequently coded with the diagnosis of P22.0- Respiratory distress syndrome of newborn, which assigns DRG 790. Record reviews support a more accurate diagnosis of P22.1 TTN (Transitory Tachypnea of Newborn), P22.8-Other respiratory distress of newborn; or P22.9-Respiratory distress of newborn, unspecified,

which assigns DRG 794-Neonate with other significant problems. Upcoding to DRG 790, results in an increased payment of between $5,000 and $20,000, per claim.

RDS vs TTN (Transitory Tachypnea of Newborn)

Respiratory distress syndrome of newborn (or hyaline membrane disease), P22.0, caused by developmental insufficiency of pulmonary surfactant production and structural immaturity in the lungs., is also referred to as Type I respiratory distress of the newborn. As the disease progresses, the baby may develop ventilatory failure (rising carbon dioxide concentrations in the blood), and prolonged cessations of breathing (apnea). Historically, the differentiating treatment was endotracheal administration of exogenous surfactant (Curosurf, Survanta), however now we are seeing surfactant being given to full term newborns as treatment for any respiratory distress condition.

Transitory tachypnea of newborn, P22.1, is also referred to as Type II respiratory distress of newborn and by definition resolves within 6-24 hours of birth. TTN infants have tachypnea (respiratory rate greater than 60 breaths per minute), may be cyanotic and have increased work of breathing manifested by nasal flaring, mild subcostal and intercostal retractions and expiratory grunting.

Recovery of Overpayments

Recovery of overpayments for DRG 790-RDS. Includes appealed and non-appealed, none withdrawn:

6/1/16-Current	90 claims	$892,349.97

Audits

The UOIG may conduct financial or performance audits of any Medicaid Program. During SFY 2017 the Audit Section completed one audit that was initiated in SFY 2016 and opened 12 additional audits.

The following chart shows what audits were opened in SFY 2017 and their current status.

Audit Name	Status as of 1 Nov 2017
Medicaid's Dental Managed Care Plan	Working- Near Completion
Survey & Certification Corrective Action Plans	Working- Near Completion
Deficit Reduction Act Audit	Completed
Ambulance Billing	Working- Rough Draft
Medical Supply Stores	Working- Survey Work

MRI without Prior Authorization	Hold
X-ray Services	Hold
Midtown Manor	Working- Manager Review
School Based Services	Working- Site Visits
Sleep Studies	Transition to Evaluation
Laboratory Services	Working- Requested Records
Chiropractors	Working- Survey Planning

Table 2- SFY 2017 Audits

Most completed UOIG Audits can be found on the UOIG webpage at oig.utah.gov.

Administrative Hearings

During SFY 2017 the UOIG continued to improve processes throughout the Office. The improvement of processes has greatly contributed to better quality post-payment reviews and investigations. As a result the numbers of administrative hearings has declined substantially. In SFY 2015 the Office issued 656 Notices of Recovery and received 271 requests for hearing. During SFY 2017 the Office issued 1654 Notices of Recovery and received only 159 requests for hearing. These numbers indicate a significant improvement in

Policy Reviews

In accordance with Utah Code 63A-13-202(2)(c) the Office conducts reviews of Medicaid Provider Manuals and Medicaid Information Bulletins (MIB) prior to Medicaid releasing the document to the public. These policy reviews help deconflict Medicaid policies. During SFY 2017 the UOIG performed 24 policy reviews. The 24 policy reviews generated 114 recommendations to Medicaid. Of those 114 recommendations 55 (48%) were officially accepted, although that number is potentially higher since a number of the policy reviews with recommendations went unanswered.

Training

Training is one of the most critical aspects of the UOIG's mission and should not be overlooked by key stakeholders as a key function of the Office. For purposes of this report training is divided into two sections, external and internal.

External Training

External training is any training conducted with any entity or person outside of the UOIG. External training serves two purposes. First, it helps change billing behavior that does not reach the level of fraud or abuse, but can be classified as waste and secondly, it helps

educate employees and providers on red flags for fraud, waste or abuse and how to report those. During SFY 2017 the Office conducted 29 provider training engagements, 8 partner (Fraud Control Unit, Medicaid, etc) engagements. These types of training engagements are vital for changing behavior within the provider community and for giving partner organizations the tools necessary to assist the UOIG in its mission of identifying and investigating fraud, waste, and abuse.

Internal Training

Internal training is training conducted for employees of the Office to keep their particular skills and certifications current. These training events are conducted both within the Office and with professional organizations at conferences. Additionally, the Office frequently sends employees to training events at the Medicaid Program Integrity Institute in Columbia, South Carolina which is 100% funded by the Centers for Medicare & Medicaid Services (CMS). These training events provide opportunities to learn about current fraud, waste, and abuse schemes and to learn best practices from all of the other state's and territories' Medicaid Program.

During SFY 2017 four UOIG employees certified as Certified Fraud Examiners (CFE) with the Association of Certified Fraud Examiners. Two employees certified as Certified Inspector General Investigators (CIGI) and two additional employees certified as Certified Inspector General Auditors (CIGA) with the Association of Inspectors General.

Cost Avoidance and Deterrence

Cost avoidance and deterrence are both hard to quantify, but are nonetheless important factors of Program Integrity that should not be overlooked due to the significant impact on the Medicaid Program. The UOIG strives to increase provider and stakeholder awareness through training, audits, investigations, post-payment reviews, self-audits, inspections, and evaluations. The UOIG's primary goal is to change improper billing practices and to assist Medicaid through policy recommendations that increase the efficiency of the overall Medicaid program in Utah.

While unquantifiable at this time, the Inspector General estimates the Office has improved efficiencies through action it has taken over the past year to be about $10,000,000. Office management is currently working on a methodology that will help quantify these amounts in future reports.

SFY 2017 UOIG Tabulated Data

SFY 2017 Taxpayer Funds Collected	
Cash Collected	$900,979
UOIG Initiated Credit Adjustments	$1,549,364
UOIG Requested Rebilled Claims	$628,158
Recovery Audit Contractor Recoveries	$422,099
Health Information Technology Recoveries	$2,835,831
Total Recoveries	**$6,336,431**

Projected Cost Avoidance	
Estimated Cost Avoidance	$10,000,000

Return on Investment	
ROI	236%

Investigations	
Cases opened	741
Total claims reviewed	8240

Recovery Letters	
Total recovery letters sent	1654
Uncontested recovery letters	1529
Total hearings requested	159
Undecided- still in hearing process	6
Closed in favor of UOIG	102
Closed in favor of Provider	33
Closed by stipulated agreement	18

Referrals to Other Agencies	
MFCU	1
ORS	1
DWS (Eligibility Fraud Referrals)	31

Audits	
Open Audits in SFY 2017	13

Policy Reviews	
Medicaid Policy	24
Policy Recommendations	114

Training Events Conducted	
External	37