Fraud, Waste and Abuse Overview

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Utah Office of Inspector General

Bottom Line Up Front

Medicaid and OIG are strong partners in providing oversight of the Medicaid program. Everyone who works within the Medicaid program is an important to that oversight.

Fraud, waste and abuse affect every American. It drains taxpayer dollars and provider resources from the Medicaid program. It contributes to rising health care costs for all.

The Utah Office of Inspector General (Utah OIG) was created in 2011 by the legislature to serve as the oversight entity of Medicaid. The Utah OIG conducts oversight through ***policy reviews, investigations, utilization reviews, audits and training***.

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OIG Training Support
Partnership Building

- OIG Mandated by Statute to Provide Training:
  - Utah Code 63A-202-1(p):
  1. **Medicaid**:
     - "Agencies and employees on identifying fraud, waste and abuse of Medicaid funds"
       - This annual training event
       - Periodic training available on request
  2. **Providers**:
     - "Health care professionals and providers on program and audit policies and compliance"
       - Provider Training Events
       - Periodic training to specific providers
  3. **On Request**:
     - Available to assist with training.

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Oversight

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Why Oversight?

- **Medicaid**:
  - Federal and State Funded
  - Low-income individuals and families
  - Overlap with Medicare possible
  - ***62 million Americans – 1 in every 5 covered***
  - Bottom line: Administers health care for the poor.

- **CMS (Division of HHS)**:
  - Guidance on Medicaid programs, administers Medicare
  - Medicaid considered high-error program:
    - ***Collectively processes 3.9 billion claims, $430 billion each year.***

- **Medicaid is susceptible to improper payments**.

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Improper Payments

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Improper Payments

- Government Accountability Office:
  "Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements."
    - Funds go to the wrong provider.
    - Incorrect amount – does not comply with policy.
    - Documentation does not support the payment.
    - Uses funds in an improper manner.

- ***Everyone can participate in oversight of Medicaid.***

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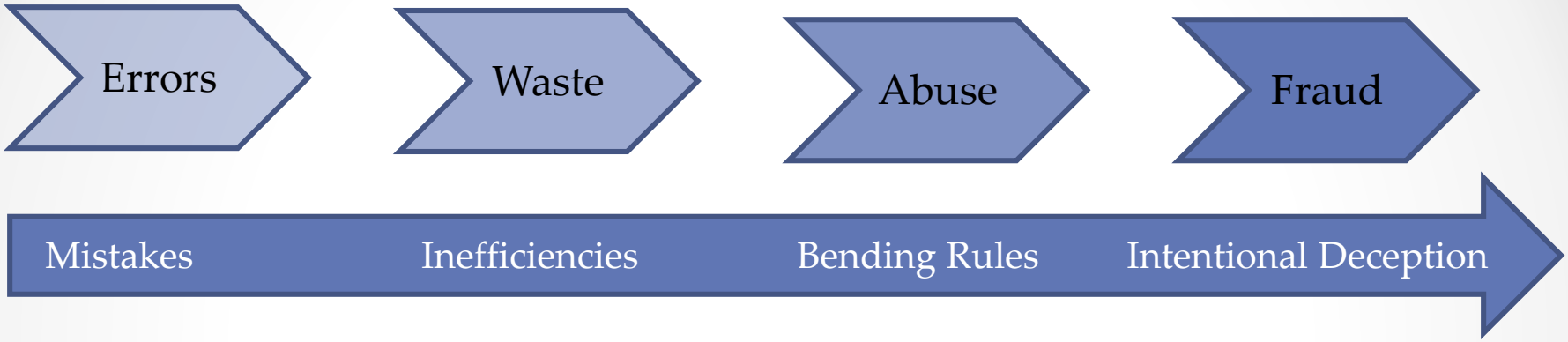
Causes of Improper Payments



- Common errors include ***insufficient documentation***:
  - CMS reported in 2015 that insufficient documentation was the "most common error."
  - Overpayments may have been proper, but lack of documentation caused recovery as overpayment.
- Majority of improper payments are unintentional errors (CMS, 2015).

- Utah OIG identifies all causes of improper payments:
  - From mistakes to intentional deception.

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Utah OIG Statute – §63A-13-102 Definitions

- **Fraud**:
  - "*intentional or knowing*:
    (a) ***Deception, misrepresentation, or upcoding*** in relation to Medicaid funds, costs, a claim, reimbursement, or services; or
    (b) a violation of a provision of Sections 26-20-3 through 26-20-7."
- **Abuse**:
  - "(a) an action or practice that:
    (i) is inconsistent with sound fiscal, business, or medical practices; and
    (ii) results, or may result, in unnecessary Medicaid related costs; or
  - (b) ***reckless or negligent upcoding***."
- **Waste**:
  - "***Overutilization of resources*** or inappropriate payment."

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Waste

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Waste

- **Definition**:
  - ***Over-utilization of services or practices that result in unnecessary costs***.
  - Needless or impractical consumption or expenditure without adequate return.
- ***Examples of Waste***:
  - Providing services not medically necessary.
  - Providing extra services not needed.
  - Extending services beyond what is necessary.
- **Office Experts - Medical Reasonableness**:
  - Nurse Investigators are the sole subject matter experts within Utah OIG on what is medically necessary.
    - Experience, training and education to provide guidance on medically necessary services versus services not reasonably expected to contribute to care and recovery of patient.
- **Questions**:
  - Should additional diagnostic studies been ordered?
  - When did patient reach maximum medical improvement (MMI)?
  - Was physical therapy or rehabilitation services unnecessarily extended?

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Abuse

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CMS Guidance on Abuse

- **CMS Definition of Abuse**:
  - "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."
  - ***Similar to fraud except no requirement to prove act committed knowingly, willfully or intentionally***.

- *Examples of Abuse*:
  - Duplicating already performed services.
  - Ordering excessive or unrelated tests.
  - Prescribing unrelated medication.

- **Key Takeaway**:
  - Primary difference between Fraud and Abuse is intention.

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Fraud

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CMS Guidance on Fraud

- **CMS Definition of Fraud**:
  - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person."

- ***Examples of Fraud?***:
  - Falsifying medical records.
  - Submitting claims for services not provided.
  - Intentionally "upcoding" codes to receive a higher payment.
  - Presenting false identity, credentials or qualifications.

- **Key Takeaway**:
  - Intentional act to deceive.

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National Fraud Cases

- **Home Health Agency**: Owner and operator of a Miami HHA sentenced to 8 years prison and $21 million restitution associated with a fraud scheme. ***Services were not provided or were not medically necessary***.

- **Home Health Agency**: Four people sentenced to up to 10 years prison for $6 million fraud scheme of ***billing for services not provided***.

- **Pharmacy**: Pharmacist forged provider names and credentials, used names of children of customers, to bill prescriptions for an expensive drug (TOBI – cystic fibrosis drug).

- **DME**: Louisiana provider billed for DME and orthotics that patients did not need or want, and in some cases were not provided. $3.2 million in fraudulent claims.

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Perpetrators of Fraud

- **Perpetrators**
  - Medicaid Providers
  - Third Party Billers
  - Recipients
  - Others:
    - Anyone that can influence claims, payments or services.
    - Any person participating in the program.

- ***Fraud schemes can come from anyone*** that can influence or change the outcome of billing, services, eligibility and records, resulting in a benefit that, but for the fraud, they would not have received.

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Common Recipient Fraud

- **Eligibility Fraud**:
  - Misrepresenting circumstances to qualify.
- **Card Sharing**:
  - Compromises beneficiary's medical record.
  - Danger of identify theft.
  - Payment for services for person other than beneficiary.
- **Doctor Shopping**:
  - Obtaining multiple prescriptions for the same drug.
- **Drug Diversion**:
  - Deflection of prescription drugs from medical sources into the illegal market.
  - Use of prescription drugs for non-medical purposes.
  - Forging or altering prescriptions.
  - Obtaining prescriptions under false pretense.
  - Colluding with willing prescriber/provider.
- **Personal Care Services**:
  - Patients collaborating to submit false claims.

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Most Common Fraud and Abuse

- CMS reports the following as the most common types of fraud and abuse in Medicaid:
  - Medical identify theft
  - Billing for unnecessary services and equipment/supplies
  - Billing for services or items not rendered
  - Upcoding
  - Unbundling
  - Billing for non-covered services or items
  - Kickbacks
  - Recipient fraud

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Upcoding

- **What is upcoding?**
  - Not defined by regulation:
    - Generally understood as ***billing for higher rate than services provided*** or documented in record.
  - Fraudulent or negligent medical billing.
  - Negatively impacts program funding and resources.
  - Provider or biller submits claim with more expensive CPT code than service actually performed.
  - Falsifying diagnosis to receive higher DRG or modifiers.

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Upcoding Examples

- **Services**:
  - Visit to doctor for check-up:
    - CPT Code is $50.
    - Doctor or biller assigns higher cost CPT for expanded check-up to increase claim to $100.
  - Patient is diagnosed with broken leg–when only fractured.
    - Doctor bills for CPT for casting–not performed.
    - Submits additional claim for removal of cast–not performed.
    - Paid for two services never performed.
  - Billing for more time than actually spent.
- **Pharmacy**:
  - Billing for high cost medication, but providing generic or other low cost medication.
- **DME**:
  - Billing for a motorized scooter/chair, billing for manual wheelchair.

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Upcoding Types

- **CPT Code Upcoding**:
  - Billing for higher CPT than performed.
  - Intentionally diagnosing higher than actual diagnoses to justify higher paying CPT code.
- **Modifier Upcoding**:
  - Using higher paying modifier code than allowed.
  - Medical records do not support higher paying modifier.
  - Loosely applying modifiers to receive higher payment.
  - Applying modifier code to CPT not appropriate.
- **DRG Upcoding**:
  - Billing higher DRG than services provided.
  - Including additional diagnosis codes to increase DRG.

- **Bottom Line**:
  Intentionally changing codes or adding additional false diagnosis to increase reimbursement.

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CPT Upcoding Example

- **CPT Code Range – 99211 – 99215 (Office Outpatient Visit)**:
  - Evaluation and Management Services
  - 99211: $17.55
  - 99212: $38.51
  - 99213: $64.68
  - 99214: $95.54
  - 99215: $128.06
  - Data analysis discovered a higher number of 99214s for a single provider – 117 claims
  - Medical review determined ***99214 was inappropriate in all but 2 cases***:
    - 115 claims wrongly paid at higher rate of $95.54
    - Total Paid $11,178.18
    - ***Over payment of $3,732.09***

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DRG Upcoding Example

- **DRG 794 versus 795**
- Recent fraud report indicating providers manipulating DRG 795.
  - Adding various ICD-9 codes to inflate charges.
  - Changes the DRG from 795 to 794
    - DRG 794: Neonate w/other significant problems
      - Average cost $2,568.76
    - DRG 795: Normal newborn
      - Average cost $1,246.87
    - ***Difference between two DRGs $1,321.89***
- **Possible Indicators**:
  - Provider has higher number of DRG 794 than peers.
  - Excess lines of ICD-9/10 codes
  - Are ICD-9/10 codes supported by records?

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Modifier Upcoding

- **What are modifiers?**
  - Allow for unusual services requiring excessive time or resources.
  - Extra compensation for unusual circumstances.
  - Records must support.

- **Modifier 22**:
  - Paid at an additional 10% of established fee schedule.
  - Applied to obstetrical delivery for "multiple gestations or ***complications during delivery***."
  - Additional risk of adverse outcome.
  - Provider includes and supports with additional documentation.
  - "Just listing diagnosis is not enough."

- OIG identified suspect claims using CPT Code 59514.
  - Identified some facilities using Modifier 22 at a higher rate than similarly situated facilities.
  - Medical review would be necessary to confirm compliance.

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Identify and Prevent Upcoding

- **Understand Range of Codes for Services**:
  - Some codes have a range from simple to complex services.
  - Know the policies for frequently used codes.

- **Look for Unusual Activity**:
  - Medical experts look for suspect claims.
  - Are codes billing in accordance with policies.

- **Frequent Billing of Higher Payment Code**:
  - Look for providers frequently billing higher payment codes.
    - Are lower payment codes never used.

- **Outside of Normal Distribution – Expected Frequency**:
  - Look for providers billing outside of normal expectations.
  - Conduct data analysis of provider types and codes.
    - Identify normal limits.
    - Look for providers outside of expected distribution.

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Identify & Prevent Fraud, Waste and Abuse

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Awareness and Prevention

- **Be Aware**:
  - Watch for unusual billing activities or claims.
  - First line of oversight is Medicaid.
    - Claims processing.
    - Policy questions or concerns.
- **Report**:
  - Report suspect activity to management.
  - Notify OIG of any suspicious claims.
- **Policies and Procedures**:
  - Is there a best practice?
  - Better process or procedure?
  - ***Reinforce existing policies***.
- **Partnerships**:
  - Strengthen OIG and other partnerships.
  - ***Providers want to help***.
- **Information Sharing**:
  - Regularly share lessons learned and best practices.

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Best Practices

1. **Complete Medical Records**:
   - Reinforce that providers must maintain proper records.
   - Records must substantiate claims.
   - Failure to maintain and submit adequate records results in recovery.
   - Personal Care, Medical Transportation and Unconventional Providers:
     - Issues in submitting sufficient records.
2. **Reinforce Policies**:
   - Refer providers to specific policy manuals.
   - Document guidance given to providers.
   - Providers sometimes cite Medicaid representative that authorized the service or bill.
3. **Revisit and Reeducate Longtime Providers**:
   - May rely on outdated policies.
   - Support updated policies.
   - Strengthen relationships.
4. **Training**:
   - OIG can provide additional training.
   - Tailored to specific issues or provider communities.
   - ***Partnership building and support to Medicaid program.***

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Questions?

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