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### MEMORANDUM

**TO:** Joint Legislative Oversight Committee Members on HHS Commission for MH/DD/SAS  
Local CFAC Chairs State CFAC  
NC Council of Community Programs NC Assoc. of County Commissioners  
County Managers County Board Chairs  
State Facility Directors LME Directors  
LME Board Chairs DHHS Division Directors  
Advocacy Organizations Provider Organizations  
MH/DD/SAS Stakeholder Organizations NC Assoc. of County DSS Directors

**FROM:** Dr. Craigan L. Gray  
Steven Jordan *SS*

**SUBJECT:** Special Implementation Update #93 – NC Division of Medical Assistance – Program Integrity

In 2009, Secretary Lanier Cansler launched N.C. Department of Health and Human Services (DHHS) to a new day and required all DHHS employees to work toward making DHHS the best managed agency in state government by becoming more customer focused, anticipatory, collaborative, transparent, and results-oriented.

With this initiative in mind, the Program Integrity Section of the Division of Medical Assistance (DMA) is broadening the lines of communication with stakeholders on efforts to ensure compliance, efficiency and accountability and prevent improper payments of Medicaid dollars. Below is an overview of Program Integrity efforts in North Carolina.

#### NC Medicaid Fast Facts

- \$1 out of every \$6 of the budget is spent on Medicaid (15%)
- Has a \$9-10 billion budget hence one of the largest health care companies in the state
- Serves 1.5 million people annually (15.5% of total state population) and it is projected to increase 500,000 to 700,000 people by 2014.
- Medicaid fraud/abuse and misuse is a nationally recognized problem that drains taxpayers' dollars, hurts recipients and takes valuable resources right out of the system.
- DMA and Program Integrity must be accountable for meeting benchmarks and achieving goals.

**What Is the Program Integrity Section's Mission?**

- Ensure compliance, efficiency and accountability with the North Carolina Medicaid Program by detecting and preventing fraud, waste and program abuse.
- Prevent improper payments of Medicaid dollars through cost avoidance activities, tort recoveries, recoupments and ongoing education/training of providers and recipients.

**What Are the Initiatives and Strategies of Program Integrity?**

- Provide guidance to ensure the operation of the most cost-efficient health care system possible while further enhancing the quality and appropriateness of services delivered.
- Require and support efforts where health care providers are able to identify and resolve issues themselves.
- Hold provider agencies accountable for failing to have systems in place to prevent improper billing.
- Maximize technology and statistical analysis to detect providers or recipients who are outliers or illustrate aberrant patterns of utilization.
- Elevate support and use of administrative tools of payment suspension, prepayment, and post-payment review, audits, sanctions, and individual and entity exclusion when improper payments are discovered.
- Develop and communicate to the public measures of effectiveness of Program Integrity activities, which capture cost reduction and avoidance, as well as recoveries and recoupment, and minimize the cost imposed by reviews and investigation.
- Evaluate program activities and identify areas of vulnerabilities that adversely affect system and agency accountability and modify policies and rules accordingly.

**What Are Program Integrity's Objectives?**

- Customer service
- Bridge policy with execution & education
- Track down & eliminate Medicaid fraud, waste and abuse

**What Are Program Integrity's Processes for Recoupment?**

- Detection - identify suspicious activity
- Assignment - review, prioritize and assign
- Investigation - open case, finalize and send tentative notice of overpayment
- Accounts Receivable & Payment - collect and pay federal share

**What Does Program Integrity Workload Consist Of?**

- Call intake/complaint
- Claims review
- Case investigation & research
- Provider audits and investigations
- Provider education

**What Are Some of the Projected Benefits of Program Integrity's 2011-2012 goals?**

- Enhanced provider education
- Highly scalable service delivery
- Shift to a more proactive/preventive model
- Improved guidance on reimbursement policies/provider enrollment requirements
- Improved return on investment on early detection and cost avoidance activities
- Improved detection and targeting
- Increased efficiencies
- Improved performance standards
- Reduced case time (open to close)
- Enhanced quality and auditability
- Enhanced access to modernized tools
- Improved stakeholder communications, collaboration and education

## **Program Integrity Partners in Combating Medicaid Fraud, Waste and Abuse**

### **IBM-Fraud Abuse Management Systems (FAMS)**

IBM provides the Program Integrity Unit with two solutions for detecting fraud, waste and abuse of Medicaid services in the provider community.

1. IBM Fraud & Abuse Management System

IBM's fraud and abuse management system (FAMS) uses advanced analytics to detect healthcare fraud and abuse by healthcare providers. This is accomplished through the use of peer group modeling and behavioral analysis to identify possible providers of interest.

2. IBM Infosphere Identity Insight

IBM Infosphere Identity Insight is a real-time entity resolution and analysis platform for identifying fraud. Its identity and relationship disambiguation technology helps Program Integrity and its partners recognize and mitigate the incidence of fraud, waste and abuse.

- Who is Who – Identity Resolution
- Who Knows Who – Relationship Resolution

### **Public Consulting Group**

Public Consulting Group (PCG) is the vendor contracted by DMA to support Program Integrity in the post-payment claims review initiatives; such as:

- Determining if services billed were clinically and administratively appropriate according to generally accepted standards of care, NC Medicaid coverage policies, guidelines and procedures.

### **Health Management System**

Health Management System (HMS) is the vendor contracted by DMA to support Program Integrity in the Third Party Liability Recoveries, Cost Avoidance and Credit Balance Review initiatives.

### **OptumInsight – Health Spotlight, OmniAlert and DRIVE**

- Health SpotLight and OmniAlert combined makes up the NC Fraud and Abuse Detection System provided by OptumInsight. Health SpotLight provides browse and search capabilities of paid and denied claims for the last six years as well as custom analytics to identify potential fraud and/or abuse by providers and recipients.
- OmniAlert is the NC SUR application and allows the user to rank providers or recipients based upon a variety of user defined rules. OptumInsight staff provides support to the DMA business users for each of these tools. In addition, OptumInsight staff provides data mining support to DMA staff to identify providers billing units that are more than five times the standard deviation for services.
- DRIVE is the data warehouse maintained by OptumInsight for DMA which contains the six years of paid and denied claims data upon which the Health Spotlight and OmniAlert analytics are based. Parameterized queries are provided for staff to enter dates, billing provider numbers, attending provider number, provider types and specialties, etc., to identify potential abuse, fraud, or waste.

### **The Carolinas Center for Medical Excellence**

The Carolinas Center for Medical Excellence (CCME) is the vendor contracted by DMA to support Program Integrity in the post payment Diagnosis Related Group (DRG) reviews of inpatient services to determine that appropriate DRG assignments have occurred and criteria for medical necessity of inpatient acute admissions have been met. CCME also partners with Program Integrity in performing pre-payment claims review.

### **Medicaid Fraud Control Unit (Also Known as Medicaid Investigation Unit)**

While Program Integrity identifies Medicaid fraud, the Attorney General's Medicaid Investigations Unit (MIU) takes the legal action to convict a provider of criminal fraud. The MIU coordinates their efforts with the Internal Revenue Service (IRS), State Bureau of Investigation, Federal Bureau of Investigation (FBI), Drug

Enforcement Agency, U.S. Attorney, Office of Inspector General and the Medicaid Fraud Control Units in other states to resolve fraud cases. As a general rule, once a case is taken by the MIU, Program Integrity staff involvement with the provider ceases.

## **Summary**

Program Integrity believes that an analytically-driven approach plus effective, efficient processes with enhanced governance and reporting is the formula for achieving Medicaid quality assurance and compliance. The DHHS values of being customer focused, anticipating challenges, practicing transparency in decision making, collaborating on issues and holding ourselves accountable for outcomes are the foundation for our strategic approach. Program Integrity is committed to this plan and our stakeholders.

## **Medicaid Fraud: Protect Your Tax Dollars—Why Is It Important?**

The Medicaid program is funded with state and federal tax dollars. It is designed to pay for health care and certain support services for low-income and vulnerable North Carolinians (children, pregnant women, disabled adults and seniors). Tax dollars are wasted and services are taken away from people who need them when people obtain benefits they are not entitled to or when services are delivered that don't meet the policy and requirements.

### **What Is Medicaid Fraud, Waste and Abuse?**

**Fraud:** Deception or misrepresentation made by a health care provider with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under federal requirements set forth in 42 C.F.R § 455 which relates to Medicaid.

**Waste:** The over utilization of services, or other practices that result in unnecessary costs generally not considered caused by criminal negligent actions but rather the misuse of resources.

**Abuse:** Provider practices that are inconsistent with sound fiscal, business or clinical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet recognized standards for health care or clinical policy.

### **What Medicaid Fraud Looks Like**

Most types of Medicaid fraud, waste or abuse fall into one or more of the following categories:

- Billing for “phantom patients” who did not really receive services.
- Billing for medical services or goods that were not provided.
- Billing for old items as if they were new.
- Billing for more services that could be provided in 24 hours a day.
- Billing for unnecessary tests.
- Paying a “kickback” in exchange for a referral for medical services or goods.
- Charging Medicaid for expenses that have nothing to do with caring for a Medicaid client.
- Overcharging for health care services or goods that were provided.
- Concealing ownership in a related company.
- Using false credentials for staff.
- Double-billing for health care services or goods that were provided.
- Providing services by untrained staff.

To report suspected Medicaid Fraud, Waste or Abuse, please call the North Carolina DHHS Customer Service Center toll-free number at 1-800-662-7030 or the North Carolina Medicaid Program Integrity Tip-Line at 1-877-DMA-TIP1 (1-877-362-8471).

You may submit an Online Medicaid Fraud and Abuse Confidential Complaint Form using the website [www.ncdhhs.gov/dma/fraud/reportfraudform.htm](http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm). Callers may request to remain anonymous.

Before making a report, try to get as much information as possible, including:

- The name of the provider/recipient you suspect of committing fraud. This might be a person receiving medical benefits or a health care professional, hospital, nursing home, or other facility that provides Medicaid services.
- The recipient Medicaid ID number.
- The provider ID number.
- The date of services.
- The amount of money involved, and/or a description of the acts that you suspect involve fraud.

### **Audits and Post Payment Reviews: Medicaid and North Carolina Health Choice Providers**

In accordance with Session Law 2011-399, Program Integrity authorized audits and post payment reviews conducted during the state fiscal year 2011-2012 and will utilize extrapolation of findings to determine recoupment amounts. Providers who have been designated as high or moderate risk are subject to review during this fiscal year. In addition to moderate or high risk providers, other providers may be identified for review through the use of the analytical data mining software by identifying outlier billing patterns, irregular service or referral trends. Additional methods of identification for provider review include the receipt of complaints of credible allegations of fraud or abuse and tips received through the Fraud/Abuse Tip Line.

Providers who receive post payment review will be subject to review for all services and codes authorized by their participation agreement with DMA. The review or audit may take the form of a desk review of medical records or an onsite review or a combination of both. The onsite review may be announced or unannounced.

If the audit is a desk review, providers will receive a request for medical records as part of the post payment review process. The letter will outline the exact dates of medical records or claims to be reviewed, documentation being requested and the consequences for failure to comply with the request by the date identified in the letter. Based upon DMA or contractor post payment review of the submitted documentation, the desk review may lead to an onsite review or an expanded period of review.

The results of the audits will be extrapolated to determine the final overpayment amount. The time period of extrapolation may go back for 36 months from date of payment of a provider's claim or longer as allowed by federal law or regulation or in instances of credible allegations of fraud.

### **Update to Provider Self Audit Process**

In 1999, DMA Program Integrity started a Provider Self-Audit process, which offered Medicaid providers an opportunity to conduct internal compliance audits and have a mechanism for reporting their outcomes directly to Medicaid. This process still exists, and parts of it are being expanded and incorporated into new activities introduced through NC Session law 2011-399.

In the current process, a provider may request a Self-Audit packet from Program Integrity, which contains instructions and forms to be returned to DMA. Providers will be able to access the packet on our web site in the near future. The provider will submit a Notice of Intent to Conduct Self Audit form to Program Integrity, which includes a description of the intended type of audit and anticipated date of completion. This information is assigned to a Program Integrity analyst, who works with you through the process.

NC Session Law 2011-399 offers providers the opportunity to conduct a self audit as a method for contesting the outcome of certain Program Integrity audits. As part of a provider investigation Program Integrity and its vendors review a random sample of claims from the "universe" of claims submitted by a provider over a period of time. Errors identified in the sample may be extrapolated across the full universe of claims. In cases where a "low risk" or "moderate risk" provider is notified of tentative findings of errors that could result in extrapolation, they may contest the extrapolation by conducting a self-audit. Providers should carefully review NC Session Law 2011-399, N.C.G.S. § 108C-5(n) "Payment suspension and audits utilizing extrapolation" for further details.

### **Submitting Claims for Reimbursement**

Program Integrity has identified some trends in outpatient mental health non-physician practices, independent and group. Some providers are operating after-school programs, summer programs, or non-licensed day

treatment programs and submitting claims for reimbursement from the North Carolina Medicaid Program. Medicaid only reimburses for services that are medically necessary, meets the criteria established through clinical policy and when the provider is qualified to provide the services.

A recent example included a provider who was a county school counselor and licensed as a professional counselor who operated an after school tutorial program as an outpatient mental health practice. The provider rendered free teacher-supervised tutoring services, snacks and transportation to children of lower-income families and also had his employees obtain copies of each recipient's Medicaid card. He is suspected of submitting false claims for therapy sessions to his billing agent in Florida for reimbursement from the North Carolina Medicaid program. The night before the provider was scheduled to meet with investigators his business burned down.

Defrauding the NC Medicaid program is a serious offense and will be dealt with accordingly. Sometimes the penalty includes civil and/or criminal remedies. Medicaid providers may receive a federal indictment involving wire fraud, identity theft, and arson by the U.S. Attorney's Office.

### **Medicaid and Health Choice Provider Payment**

In accordance with the federal requirements set forth in 42 C.F.R § 455.23, the Medicaid agency is required to suspend payments of providers having a credible allegation of fraud. NC Session Law 2011-399 expands DMA's responsibility to include suspending payments to providers who owe a final overpayment, assessment or fine and who have not entered into an approved payment plan with DHHS. DHHS may suspend payments to all provider numbers, who share the same IRS Employee Identification Number or corporate parent as the provider who owes the repayment or has a credible allegation of fraud.

### **Provider Responsibilities in a Program Integrity Review or Audit**

Program Integrity (PI) reviews or audits may be conducted in person or by mail (referred to as a desk review). Onsite visits to providers and their recipients may be announced (this is a routine procedure) or unannounced. These reviews may be referred to as post payment reviews, quality assurance reviews or compliance audits.

In order that these reviews run as smoothly as possible, providers should adhere to the following steps when a review has been initiated. PI will request medical and/or financial records either by mail or in person. The records must be provided upon request. The intent of the record request is to substantiate all services and billings to Medicaid or Health Choice adhere to the required medical record documentation standards, substantiate provider qualifications, delivery of service in accordance to policy, requirements and rules, and that business and administrative practices are within acceptable practices. Financial or business record requests may include such documents as personnel and timekeeping records, invoices, chart of accounts, general ledger, minutes of committee meetings, audited or internally prepared financial statements, or bank loan documents. Failure to submit the requested records will result in recoupment of all payments for the services, suspension of payments, and may constitute further actions of investigation resulting in termination from the Medicaid/Health Choice program and referral to the Medicaid Fraud Investigative Unit for review for criminal or civil prosecution.

For the purpose of Medicaid and Health Choice billing, providers must maintain records for six years in accordance with the record keeping provisions of the Medicaid Provider Administrative Participation Agreement. Other record retention schedules may be required by other state or federal oversight agencies, funding streams or accrediting/certification bodies and Medicaid/Health Choice requirements do not override those requirements of other oversight bodies.

If you receive a Tentative Notice of Overpayment letter from PI, review the information in the letter and chart. There are then two options:

1. If you agree with the findings of an overpayment, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. It is the preference of the DMA to have the funds withheld in a future checkwrite. If you choose to submit a check, please send your check, along with the form

issued to you from DMA Program Integrity which includes your case number, to DMA Accounts Receivable at the address on the letter. Do not send the check to HP Enterprise Services, as this could result in a duplication of your payment or failure to accurately record the submission of the payment. Also, do NOT request that HP Enterprise Services adjust for the amount or items identified, as this could result in duplicate recoupment.

2. If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form enclosed in the letter and return to the DHHS Hearing Unit at the address on the letter. Please pay close attention to the time frames and procedures for requesting a reconsideration review.

## **Appeals**

### **Informal**

Reconsideration Review – A provider who disagrees with the decision may request an informal reconsideration review and submit additional relevant documentation for review. Please read the letter from DMA regarding the time frame for submitting a reconsideration review request. The reconsideration review is an informal procedure. The case will be reviewed by an independent Hearing Officer who will send the provider a written decision.

### **Formal**

Contested Case Hearing – If the provider is not satisfied with the outcome of the informal review, or if the provider chooses not to have an informal review, the provider may file a request for a contested case hearing at the Office of Administrative Hearings (OAH). Pay close attention to the specific time frames and procedures for requesting a contested case hearing at OAH. Once the request is received, OAH will contact the provider regarding scheduling of the case.

### **Medical Record Requests for Program Integrity Post Payment and Pre Payment Reviews**

DMA is authorized by Section 1902 (a) (27) of the Social Security Act and 42 CFR §431.107 to access patient medical records for purposes directly related to the administration of the Medicaid Program. In addition, when applying for Medicaid benefits, each recipient signs a release which authorizes access to his/her Medicaid records by DMA and other appropriate regulatory authorities. Therefore, no special recipient permission is necessary for release of records to DMA for post-payment reviews. Federal regulations and provider agreements with the Division of Medical Assistance require the provider to keep any records necessary to disclose the extent of services furnished including but not limited to all information contained in recipient financial and medical records, agency personnel records and other agency administrative records.

A provider on post payment review will receive an initial medical record request that requires copies of recipient records be sent to DMA or it's agents within ten (10) business days of the provider's receipt of the initial letter. If records are not received by DMA or it's agents within the allotted time, a final request will be sent, which states that the provider is required to provide the requested records by the end of the 5<sup>th</sup> business day from receipt of the final request letter. Failure to comply with this final request may result in a determination that the provider agency was improperly paid for all services under review for the requested dates of service. In addition, failure to produce records will be considered a credible allegation of fraud and subject the provider to immediate payment suspension and possible termination from Medicaid participation.

A provider on prepayment review will receive medical record requests as noted above, for all recipients where they submit a claim for payment to Medicaid. With prepayment review, the initial medical records request allows five (5) business days for response. If records are not received within the allotted time, a final request will be sent that requires records to be received within five (5) business days of receipt of the letter. Payment of the claims will be denied if the documentation is not received.

### **Reporting Provider Fraud and Abuse**

The N.C. Department of Health and Human Services created a poster <http://www.ncdhhs.gov/dma/fraud/FraudPoster.pdf> asking citizens to report Medicaid fraud and abuse. In a memo <http://www.ncdhhs.gov/dma/fraud/FraudMemo.pdf> dated June 4, 2010, DHHS Secretary Lanier Cansler

asked all health care agencies and private health care providers to print and prominently display the poster in their offices. These efforts continue to be a priority for DHHS and the health care industry. Combating fraud/abuse and over use of services is an effective way to reduce health care costs without compromising recipient care.

You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

Please contact DMA/Program Integrity at 919-647-8000 with any questions related to this Implementation Update.

As a reminder, all Medicaid-enrolled providers billing for services are expected to adhere to all Medicaid and Health Choice policies and guidelines and are expected to stay informed about any changes. Medicaid Bulletins are published monthly and may include articles not found in the Implementation Updates. Medicaid Bulletins can be found at: <http://www.ncdhhs.gov/dma/bulletin/index.htm>.

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|-----|--------------------------------------|----------------|
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