Working Together to Achieve Program Compliance

Magellan Behavioral Health of Pennsylvania, Inc.

9/17/13
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Partnership

• Providers, Magellan, Counties, State Government Oversight Agencies

• Working together to reduce the occurrence of misuse of program dollars
Partnership

• The common goal shared is to decrease future incidents of fraud, waste and abuse (FWA) which can be enhanced by:

  Awareness and understanding of regulations, laws and expectations

  Ongoing training of staff regarding above as well as in FWA prevention and reporting

  Implementation of an effective compliance program

  Screening of potential employees and monthly screening for existing staff

  Open communication among all entities
Partnership

• HealthChoices Behavioral Health Program -- Program Standards & Requirements (PS&R) – Appendix F and HealthChoices Behavioral Health Agreement:

  FWA Program Requirements: Includes “Duty to Report Suspected Fraud, Waste and Abuse to the Department” as a requirement. This means to the Bureau of Program Integrity (BPI) and to Attorney General’s Medicaid Fraud Control Section

  2013 Enhancement: Reporting also includes to the Office of Mental Health and Substance Abuse Services (OMHSAS) Field Office
Audits Conducted by Magellan Behavioral Health of Pennsylvania, Inc.

- Purpose of auditing
- Types of audits
Audits: Purpose

- Audits are one component of Magellan’s oversight of the quality and compliance of its network providers and are conducted to:

  Provide feedback to providers on documentation standards for on-going education;

  Monitor provider compliance with Medicaid billing guidelines;

  Verify that treatment record keeping practices meet Magellan standards;

  Investigate quality concerns and reported concerns of providers which may indicate that a provider does not meet Magellan standards;

  Investigate complaints related to the clinical or administrative practices of providers, as determined by regional staff on a case-by-case basis;

  Ensure providers have a compliance plan and policies and procedures that detail provider expectations
Audits: Types

• **Clinical (Treatment Record Review):**
  
  Focuses on monitoring network provider treatment record documentation against Magellan standards, as well as reviewing the quality of service delivery
  
  Major categories include: member rights, initial evaluation, individualized treatment plan, ongoing treatment and coordination of care, level of care specific items, clinical practice guidelines, and metabolic syndrome screening
  
  Conducted by a Master’s level clinician

• **Compliance:**
  
  Focuses on monitoring network providers to ensure proper elements of a compliance program are in place
  
  Major categories reviewed include: provider internal claims audits, provider compliance program components i.e. policies and procedures, trainings and mandatory reporting.
  
  Conducted by a Master’s level reviewer
Audits: Types

• **Claims:**
  
  Focuses on monitoring network providers to detect and/or recover potential fraud, waste or abuse specific to billing practices, as well as to ensure network providers are complying with state and federal regulatory compliance and fraud reporting requirements.

  The claims audit reviews for: documentation supporting the service that was billed; correct billing code utilization; billing per Medicaid regulations.

  Conducted by a Master’s level reviewer

• **Network:**

  Focuses on monitoring providers for adherence to credentialing standards

  Major categories reviewed include: staffing/human resources, physical plant, and type of claims submission process (electronic or paper)

  Conducted by a Bachelor’s level reviewer
Audits: Types

- **Magellan Special Investigations Unit (SIU)**

  The Magellan Special Investigations Unit (SIU) is responsible for protecting the assets of Magellan and its clients by detecting, identifying, and deterring fraud, waste and abuse by conducting audits of internal and external sources of information.

  The following are examples that may warrant a referral to the SIU but are not limited to only these situations:

  - Whistleblower or informant allegations/involvement
  - Requirement to expand scope of investigation or further data mining activities (i.e. expansion to larger time period or sample; analysis of billing patterns)
  - Provider has been re-audited by the CMC and the same issues are still occurring after CMC has been providing technical assistance
Fraud, Waste & Abuse- Definitions

• **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. It includes any act that constitutes fraud under applicable Federal or State law.

• **Waste**= Acting with gross negligence or reckless disregard for the truth in a manner that results in any unnecessary cost or any unnecessary consumption of a healthcare resource.

• **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 fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.
Examples of Fraud:

• Intentionally billing for services that were not provided
• Falsifying signatures
• Rounding up time spent with a member
• Misrepresenting a diagnosis to justify payment or obtain a higher reimbursement
• Altering claim forms
• Billing separately for services that should be included in a single service fee
• Doctor shopping" – when a patient who may or may not have a legitimate physical ailment goes from doctor to doctor to obtain multiple prescriptions for narcotic painkillers
• Using another person's Medicaid card/ information to obtain care
• Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for referrals of patients)
Examples of Waste:

- Using excessive services such as office visits
- Providing services that aren’t medically necessary
- Provider ordering excessive testing
Examples of Abuse:

• The state of mind is what separates Fraud from Abuse.

• Examples:
  
  Services that are billed by mistake
  
  Misusing codes: code on claim does not comply with national or local coding guidelines; not billed as rendered
  
  Billing for a non-covered service
Compliance Program Guidance

- Definition and Background
- Seven Essential Elements of a Compliance Program
Compliance Program Guidance

• An effective compliance program must be an ongoing process that includes prevention, detection, collaboration and enforcement.

• Department of Health & Human Services (HHS) Office of Inspector General (OIG) enforces regulations under the Medicare and Medicaid laws which are administered by the Centers for Medicare and Medicaid Services (CMS)

• Seven elements of an effective compliance program:

  1. Written policies and procedures
  2. Designation of a Compliance Officer and Compliance Committee
  3. Effective training and education
  4. Effective lines of communication
  5. Auditing and monitoring
  6. Enforcement and discipline
  7. Response and prevention
Compliance Program Guidance

1. Written Policies & Procedures

• Standards/Code of Conduct

  Guidelines for business decision-making and behavior

• Policies & Procedures

  Specific, realistic and measurable

  Focus on areas of risk:

  Examples: Record retention; internal assessments; employee training; self-disclosures; whistleblower protection; sanction and exclusion checks; billing practices; documentation requirements, etc.

  Conduct periodic reviews at least annually

The only thing worse than not having a policy is having a policy and not following it.
Compliance Program Guidance

2. Designation of a Compliance Officer and Compliance Committee

• Compliance Officer

  Primary responsibility is to oversee and monitor the implementation of the compliance program

  Authority, independence

  Advise and provide recommendations to management, board of directors, and employees

• Compliance Committee

  Assist in implementation of compliance program

  Advise Compliance Officer

  Beneficial to have committee members who are diverse in their areas of expertise
Compliance Program Guidance

3. Effective training and education

• Formal training

  Require participation of all employees

  Content includes requirements/expectations of the Compliance Program (i.e. policies, confidential communications, hotline, Code of Conduct, regulatory requirements).

  Upon hire and annual refresher trainings

  Attestations confirming completion of training

  Additional trainings for staff who may be more involved in high risk areas

• Informal training (ongoing)

  Posters, email communications, newsletters, “compliance awareness week”, etc.
Compliance Program Guidance

4. Effective Lines of Communication

- Access to Compliance Officer
  - Open door policy; direct access to Compliance Officer
  - Confidentiality and non-retaliation policies
  - Environment where employees feel comfortable to report concerns

- Reporting Noncompliance
  - Hotline (anonymity should be an option); email system; drop box; face to face
  - Policy/Procedure regarding tracking and investigating reports
Compliance Program Guidance

5. Auditing and Monitoring

• An effective and successful compliance program has a process of constant evaluation—a process for continually improving upon compliance activities

• Auditing

   Areas such as claim submissions, compliance program processes, record retention, compliance with regulations, any areas of concern previously identified internally or by an external entity

   At least annually

• Monitoring

   Regular, ongoing review

   Effective techniques include: employee interviews; on-site visits; questionnaires; focus groups; reviews of records, reports; data trend analyses; including compliance related questions in exit interviews
Compliance Program Guidance

6. Enforcement and Discipline

- Enforcing standards of conduct and policies/procedures should be consistent and fair.

- Include a written policy statement that outlines the degrees of disciplinary actions that may be imposed on employees for failure to comply with the standards/regulations/policies, etc. Policy should include:
  - Sanctions for non-compliance as well as failure to report non-compliance.
  - Outline of disciplinary procedures.
  - Staff responsible for imposing disciplinary action.
  - Discipline will be fair and consistent; punishment should be proportionate with the offense.

- Conduct background and sanction list checks on new hires and ongoing regular reviews of current employees against the federal healthcare sanctions lists.
Compliance Program Guidance

7. Response and Prevention

- Once misconduct or a violation has been detected, an organization must respond appropriately.

- Finding an issue is an indication that the compliance program is working, since one of the goals of a compliance program is detection

- Develop a plan of action

  Take immediate steps to stop or correct the alleged source of misconduct/violation

  Thorough internal investigation (timeframe, process, documentation)

  Outside consultants option—make sure CO is part of the team
Compliance Program Guidance

7. Response and Prevention (cont.)

Documentation should include:

- Description of complaint and method of reporting
- Description of investigation process
- List of documents reviewed and employees interviewed—any questions or notes
- Changes made to any policies/procedures, if applicable
- Documentation of disciplinary actions taken
- Final report with corrective actions taken and planned

- Disclosing/reporting to government authorities

If there is credible evidence of misconduct, it should be reported to OIG and CMS within 30 days of discovery.
Provider Presentation
Exclusions and Screening
Exclusions and Screening - Why Check?

- No federal health care program payment may be made for services or items either furnished by an excluded individual or entity; or directed or prescribed by an excluded provider

- Prohibition includes those not providing direct patient care (i.e. office staff, administrators, managers, board of directors, etc.)

- Thus, who should be screened?
  A: *All employees, vendors, contractors, service providers, and referral sources*

- What are risks for failure to do so?
  A: Civil monetary penalty for employing an excluded individual= up to $10,000
  A: You could also be excluded from participation in Federal health care programs including PA Medicaid
Exclusions and Screening - How and Where to Check

- **List of Excluded Individuals and Entities (“LEIE”)**
  Identifies individuals or entities excluded nationwide from participation in any federal health care program. If included on the LEIE individuals are **ineligible** to participate, either directly or indirectly, in the MA Program.
  
  [http://oig.hhs.gov/fraud/exclusions.asp](http://oig.hhs.gov/fraud/exclusions.asp)

- **DPW’s Medicheck List**: Database maintained by DPW.
  Includes providers, individuals, and other entities that are precluded from participation in Pennsylvania’s MA Program.
  
  [http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S_001152](http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S_001152)

- **System for Award Management (SAM)**: General Services Administration world wide data base
  Parties excluded from receiving federal contracts, certain subcontracts and certain federal financial and nonfinancial assistance and benefits
  

- **MA Bulletin 99-11-05**: Suggests Medicaid providers do monthly screenings to look for excluded individuals and entities
Laws & Statutes
Legal Statutes

Federal False Claims Act (FCA):

• Imposes liability on an person who submits a claim to the federal government that he/she knows (or should know) is false.

• FCA provides that private parties may bring an action on behalf of the U.S. Qui Tam (private parties) may share in a percentage of the proceeds from an FCA action or settlement.

• Examples:
  1. False Billing
  2. Duplicate Billing
  3. False Cost Reports
FCA Examples

1. False Billing:
   - Physician submits a bill for medical services that he/she knew were not provided.
   - Misrepresenting services rendered (up-coding, inappropriate coding).
   - Misrepresenting the nature of the patient’s condition (DRG Fraud).

2. Duplicate Billing:
   - One service keyed or coded two separate ways. Produce two bills for the same service.

3. False Cost Report:
   - Seeking reimbursement for costs that are not related to patient care.
   - Inflating costs relating to pt care-included cost of non-covered services.
Anti-Kickback Statute

Criminal statute that prohibits the exchange (or offer to exchange) of anything of value, in an effort to induce or reward the referral of federal healthcare program business.

Two different types of payment:
- Disguised payment made in return for patient referral.
- Non cash payment to the physician in return for patient referrals.

Type of Statute:
- Intent based that requires the party to “knowingly and willfully engage in the prohibited conduct.”
Whistleblower Protection Act

To encourage individuals of conscience to report unlawful activity under the False Claims Act.

The Act affords the whistleblower with 2 main legal protections:
  • Protection from retaliatory action
  • The provision of conditional anonymity

The first statute to protect whistleblowers in the U.S. was the Federal False Claims Act. Despite being unpopular with businesses, the federal FCA has withstood Supreme Court scrutiny. Today it serves as the most important of the many federal and state laws protecting whistleblowers.
Whistleblower Protection Act (cont)

The Whistleblower Statute falls into 2 categories:
1. Those that encourage whistleblowers by giving them some form of compensation for their action, such as the FCA.
2. Those that protect the whistleblower from retaliation, which constitutes the majority of state and federal statutes.

As of 2002, ALL 50 states provide some sort of Whistleblower protection.
Stark Law

- Applies to physicians only.

- Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement.

- Referrals and claims that violate the Stark Statute are each punishable by a $15,000 Civil Money penalty.
Does it Violate Stark?????

1. A family physician invests in an imaging center to which he does not refer Medicare or Medicaid patients. However, he does refer to an orthopedist who orders an MRI from the center. Does this violate Stark?

Answer: YES The orthopedist’s order is a downstream referral for a designated health service (DHS).

2. A family physician’s husband is a pathologist and shareholder in the only group in town that performs hospital laboratory services. The family physician refers her Medicare and Medicaid patients to this group for hospital laboratory services and the pathologists bill Medicare for their own services. Does this violate Stark???

Answer: YES The family physician and the pathologist are immediate family members. Stark would require that either the family physician not refer her Medicare and Medicaid patients to that group or that the husband not be a shareholder in the pathology group.
Other Laws And Statutes

1. **Civil Monetary Penalties Law**: Prohibits a hospital from knowingly making payments to a physician to induce reduction or limitations of services to Medicare or Medicaid Beneficiaries.

2. **HIPAA (Health Insurance Portability and Accountability Act)**:
   - Provides federal protections for individual health information held by covered entities and their business associates.
   - Gives patients an array of rights with respect to that information.
   - At the same time, the Privacy rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.
Deficit Reduction Act Of 2005

• Restrains federal spending and leaves more money in the hands of the American people.

• By 2030: spending for Medicare, Medicaid, and Social Security alone will be almost 60% of the entire federal budget.
Audit Trends Identified
Trends/ Findings from Magellan Integrated Audits

- Missing Documentation (i.e. notes, encounter forms)
- Billing for services not rendered
- Documentation supports fewer units than billed
- Clinical documentation (quality and quantity) does not support the units billed
- If applicable, sign-in/encounter forms in record are missing or do not support units billed
- Staff Signature missing
- Staff Credentials missing
- Date of progress note does not match date of service billed
- Time in/time out not documented
- No AM or PM noted with times in progress notes
- Billed the incorrect code/modifier
- Service provided is not service billed

- Billing is not consistent with MA regulations for LOC
- Overlapping services
- Rounding up of units
- Treatment plans not signed by the member or by provider or not updated in accordance w/ applicable MA requirement
- No Treatment plan present in the record
- Identical/nearly identical treatment plans
- Identical or nearly identical assessment or progress notes
- Billing for travel time when prohibited
- Greater than ten members participating in a group session
- No breaks in time (consecutive services provided in different physical locations)
- Billed for non-billable services
- Combining partial units to make a whole unit
Resources
PA Regulation Resources

• Chapter 1101: General Provisions
  1. §1101.51 Ongoing responsibilities of providers
     o No treatment plan
     o Provider Credentials/Signature missing
     o No documentation provided/present
  2. Record keeping requirements and onsite access
  3. General standards for medical records

• PA Medical Assistance Bulletin 29-02-03, 33-02-03, 41-02-02 Documentation and Medical Record Keeping requirements
  1. Session time not listed
  2. Provider Credentials/Signature missing
  3. No documentation provided/present
PA Regulation Resources (cont.)

- PA REGULATION 055_§ 1153.52 : Payment conditions for various services:
  1. No treatment plans.
  2. Time recorded does not support units billed.
  3. No documentation provided/present.

- PA REGULATION 055_ § 1153.2 : Definitions:
  1. Time recorded does not support units billed.

- MA Bulletin:
  www.dpw.state.pa.us/publications/bulletinsearch/index.htm

- PA Code Title 55:
  http://www.pacode.com/secure/data/055/055toc.html
Other Resources

• False Claims Act:
  
  http://www.justice.gov/civil/docs_forms/CFRAUDS_FCA_primer.pdf

• Comparison of the Anti-Kickback Statute and Stark Law:
  

• Stark Law:
  
  http://starklaw.org/

• Guidance on the Federal Anti-Kickback Law:
  
  http://bphc.hrsa.gov/policiesregulations/policies/pal199510.html

• Whistleblower Protection Act:
  
  http://www.whistleblowers.gov/
Resources (cont.)

• Deficit Reduction Act of 2005:
  

• HIPAA:
  
  http://www.hhs.gov/ocr/privacy/index.html
You Ask, “How do we avoid claims errors/retractions?”

• Do what we do! Keep a binder of the Regulations and Bulletins that pertain to the level of care that your facility provides.

• Check for updates on the Internet- Our department checks on a weekly basis for any updated Bulletins or Regulations.

• Have you checked out our website? [http://www.magellanofpa.com](http://www.magellanofpa.com) It’s a great resource, full of information directly from Magellan!

• Every month our department sends out an “E-MAIL BLAST” regarding topics pertaining to selected level(s) of care or issue(s). Do we have your updated staff and email contact information for our E-MAIL BLASTs?

• P.S.- Keep these in your binder too!

• P.S.S. - Don’t forget about the Webinars that Magellan hosts!
You Ask, “How do we avoid claims errors/retractions?” (cont)

• You checked the Net, referenced www.magellanofpa.com, read over the applicable Regulations/Bulletins, and still don’t have the answer to your questions? Then, please contact us either by email or telephone.
The Ultimate Goal

• Magellan strives to provide opportunities for continued education in order to increase one’s knowledge, and promote optimum care for your clients, our members.

• Together, we can achieve this ultimate goal. At the end of the day, it is about doing what is right for your clients, our members, so they have the resources and knowledge to be their own advocate!
Contact Information

• Bureau of Program Integrity (BPI)
  ❑ 1-866-DPW-TIPS (1-866-379-8477)

• PA Office of Inspector General (OIG)
  ❑ To report suspected welfare fraud against an individual or business call: 1-800-932-0582
  ❑ To report suspected fraud, waste, misconduct or abuse in Commonwealth programs, operations, or contracts call: 1-717-772-2644 or toll free at 1-877-888-7927
Magellan Contact Information

• Magellan Special Investigation Unit (SIU)
  ➢ 800-755-0850
  ➢ SIU@magellanhealth.com

• Magellan Corporate Compliance Department
  ➢ 800-915-2108
  ➢ Compliance@magellanhealth.com

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