The Importance of Documentation
Ensuring Payment and Avoiding Fraud Investigations

July 17, 2012
Objectives

- Understand:
  - Documentation requirements
  - The mission and activities of DBHS’ Corporate Compliance Program
  - Healthcare fraud and abuse
  - Your responsibility to report suspected fraud or abuse and how to report it
  - The Federal False Claims Act
  - How you can prevent fraud and program abuse
Office of Audit and Evaluation

• Within the:
  – Bureau of Corporate Compliance
  – Division of Behavioral Health Services
  – Department of Health Services
  – State of Arizona

• We conduct:
  – Provider audits
  – Manager-requested audits and evaluations
  – Other duties as assigned
Provider Audits

• Part of DBHS corporate compliance plan
• Based on variety of methods
• Use standard audit program
• Audit period and number of BHRs vary
• Billing supported by adequate documentation
• Review assessments, service plans, & progress notes
OAE Audit Methodology

• Is the paid encounter or claim supported by a:
  – Medical necessity
  – Covered behavioral health service
  – To an enrolled behavioral health recipient
  – Provided by a qualified behavioral health provider

• Is the encounter or claim evidenced with:
  – Assessments
  – Individualized service plans
  – Progress notes
Documentation

If it is not documented, it never happened!
Medical Necessity

• Medical necessity is determined by:

  – a **current** assessment containing a covered behavioral health diagnosis, signed by a behavioral health professional or other authorized person; and

  – a **current** and properly executed treatment plan, setting forth treatment for the diagnosis or diagnoses set forth in the assessment.
Progress Notes

• Progress notes are audited to determine if:
  – The service provided is a covered behavioral health service and supports a need identified in the treatment plan;
  – The service’s start and end times are identified;
  – The number of units identified match the number of units billed; and
  – It contains the proper signature, credentials, and date.

• At a minimum, all of these elements must be present to validate the billing. This methodology is consistent with AHCCCS and CMS requirements.
Reporting

Our audit reports are provided to DBHS management, the appropriate T/RBHA, and the provider. Actions as a result of the audit are taken at the direction of DBHS management.
Other Audits

- **CMS PERM Audits** - The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.
  - The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.
  - The error rate is not a “fraud rate” but a measurement of payments made that did not meet statutory, regulatory or administrative requirements.
Other Audits

- **RAC Audits** - Section 6411 of the Affordable Care Act required States and territories to establish Medicaid Recovery Audit Contractor (RAC) programs.
  - Medicaid RACs are tasked with identifying and recovering Medicaid overpayments and identifying underpayments.
OAE Audit Standards

• Independent
• Objective
• Oversight, accountability, transparency
• Improvements to government programs
Affordable Care Act

• The Affordable Care Act contains several changes related to Medicaid healthcare fraud and abuse and program integrity. One of the major changes is the new provision regarding overpayments.
• Any provider, supplier or Medicaid managed care organization must report and return any overpayment to the applicable government contractor, intermediary or carrier.
• The recipient of these overpayments is legally obligated to report and return the overpayments within 60 days of discovery regardless of who is responsible for the overpayment.
• Reporting and returning overpayments is considered an obligation under the Federal False Claims Act and failing to do so could lead to additional penalties.
For the purposes of the Affordable Care Act, there are 3 possible situations for recovery of overpayments in our system:

- Fee-for-service requires the actual recovery of the overpayment funds. Based upon the provider’s contract, the amount may need to be deducted from future FFS billing payments.

- Sub-contracted providers that receive general block payments. The RBHA would need to void the related encounters from their system, not allowing the resubmission of the encounters. This would be considered the recovery of overpaid funds by AHCCCS.

- Sub-contractors that receive their funding on a “per member, per month” or similar individually determinable basis. These overpayments would require the return of the related overpaid funds (as related to the PM/PM) to their contractor (RBHA) and void, not to resubmit, the related encounters from the system.
Fraud and Abuse

What You Need To Know
ADHS Corporate Compliance Program

• Our Mission:
  – “To deter and detect fraud and program abuse within DBHS, its contractors and subcontractors.”

• Mission accomplished through administration of Corporate Compliance Program
  – Program is administered by the Corporate Compliance Officer (CCO), the DBHS Bureau of Corporate Compliance and the DBHS Corporate Compliance Committee
ADHS Corporate Compliance Program

• “Corporate Compliance” is about fraud and program abuse not contract compliance
• The phrase “Program Integrity” is also used in statutory language – just another way of saying fraud and program abuse
What is Fraud?

• “Fraud means 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.” (42 CFR § 455.2)
The Elements of Fraud

• **The act** (evidence of wrongdoing)

• **Knowledge and intent** (*willfully* intended to commit act – generally evidenced by a pattern of wrongdoing, witness statement or admission)

• **Unauthorized benefit** (*could* result in some type of measurable benefit obtained from the act by the person or organization committing the act. Benefit does not need to actually occur, but a benefit could have occurred because of the act)
Unauthorized Benefit

• Not always financial
• Keeping, renewing or obtaining a new contract
• Keeping or improving position or salary
• Measurable benefit for another person or entity
What is Abuse?

“Abuse (program abuse) means 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. It also includes recipient practices that result in unnecessary cost to the Medicaid program.” (42 CFR § 455.2)
What is Abuse?

• With regard to Medicare/Medicaid funded healthcare programs, abuse refers to “program abuse”, not physical or mental abuse.
The Elements of Abuse

• Inconsistent, unsound practices (pattern of not following known or established laws, rules, regulations, contract requirements or industry standards or practices)

• Unnecessary costs or loss (unnecessary financial loss to a government program)

• Not necessary/does not meet standards (general disregard for professional or industry standards and practices)
Unnecessary Cost To Program

- Unintentional program losses from incorrect or inaccurate billings or encounters
- Increase in future capitation rates based upon inaccurate of inflated encounter/utilization data
- Inaccurate or inflated description of costs to run the program resulting in inflated future costs
- Maintaining or renewing a contract that otherwise would have been lost or terminated based upon inaccurate performance data
Program Losses

• Not always evident
• May not mean personal or business gain or benefit
• Possible increase in future capitation rates
• Inaccurate description of costs to run a program resulting in inflated future costs
Fraud versus Program Abuse

• Fraud:
  – Intentional
  – Always involves lies or falsehoods

• Program Abuse:
  – Can be unintentional or unknowingly
  – Resulting in a loss to a program
# Laws, Regulations and Rules

## Fraud

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Who Commits Health Care Fraud & Abuse?

- Licensed Professionals
- Paraprofessionals
- Healthcare facilities
- Insurance companies, employers, HMOs, PPOs and networks
- Pharmacies
- Patients/members and their families
- ID theft criminals and professional fraud rings
- Third-party claims processors
- Consultants
- Contractors and government employees
Who Commits Health Care Fraud & Abuse?

Anyone who:
- can bill for services
- can contract or subcontract with DBHS
- interacts with contractors or subcontractors
- has access to contractor or agency healthcare, billing or encounter data
- receives public sponsored healthcare
- can provide professional or paraprofessional healthcare services
- can identify and exploit a weakness in the system’s internal controls

Anyone who is properly motivated!
Fraud and Abuse Schemes

• **Upcoding**: Billing for more expensive treatments than were actually rendered.

• **Unbundling**: Billing for services separately instead of billing the code that includes multiple services

• **Double Billing**: Billing for the same services more than once
Fraud and Abuse Schemes

• **Billing for services not rendered**: Billing for any service which was not provided or not provided to the extent the billing describes.

• **Submission of incorrect or false data**: Submitting billing information or data that is false or inaccurate

• **Misrepresentation of services**: Billing for a covered service when an uncovered service was actually rendered
Fraud and Abuse Schemes

- **False or incorrect credentials**: Service provider does not have the necessary credentials or professional certification to provide the services as billed.

- **Alteration of a claim or medical record**: Intentional alteration of a claim or medical record in order to obtain a financial benefit or avoid financial or administrative penalty.

- **Medically unnecessary services**: Billing for services that are not necessary for the treatment of the member.
Fraud and Abuse Schemes

• **Misrepresentation of eligibility or status**: Falsely receiving or billing for services under a covered member's identity or status

• **Substitution of generic drugs**: Billing for name-brand medications, but dispensing generic versions

• **Kickbacks**: Payment to another individual in order to receive a referral or to undergo treatment
Fraud and Abuse Schemes

• **Over-utilization**: The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain

• **Unlicensed staff or facility**: Billing for services provided by an individual or facility that must be licensed or certified, but were not licensed or certified at the time the services were provided

• **Excluded provider or entity**: Billing for services while an individual or entity is debarred, suspended, or otherwise excluded from participating in the Medicaid program

• **Self-referrals**: A healthcare professional referring patients to another entity with which the referring professional has a financial relationship
Fraud and Abuse Schemes

- **Billing for used items as new**: Used durable medical equipment billed as “new” equipment

- **Excessive Fees**: Billing Medicaid substantially in excess of customary and usual charges

- **DRG Creep**: The assignment of a patient to a higher paying DRG (diagnosis related group)

- **Doctor shopping**: Receiving various narcotic medications from a multitude of physicians through deceit

- ** Encounter manipulation**: Any activity that results in encounter data (codes, number of units, levels, locations, value per unit) being reported to AHCCCS or DBHS incorrectly resulting in a financial loss to the Medicaid program
What Does Fraud Look Like?

- Medicare and Medicaid fraudsters are beating U.S. taxpayers out of an estimated $60 billion a year using a billing scam that is surprisingly easy to execute.

- "There's a healthcare fraud industry where people do nothing but recruit patients, get patient lists, find doctors, look on the Internet, find different scams. There are entire groups and entire organizations of people that are dedicated to nothing but committing fraud, finding a better way to steal from Medicare."

“Medicare fraud is a “way bigger” business than the drug business in Miami now, according to a top Justice Department prosecutor.

The criminals changed. They are more sophisticated. "They've figured out that rather than stealing $100,000 or $200,000, they can steal $100 million. We have seen cases in the last six, eight months that involve a couple of guys that if they weren't stealing from Medicare might be stealing your car.”
What Does Fraud Look Like?

• **Medicare Fraud in Miami**

• New York's Medicaid program has become so huge, so complex and so lightly policed that it is easily exploited. A yearlong investigation by the New York Times found that the program has been misspending billions of dollars annually because of fraud, waste and profiteering. A computer analysis of several million records obtained under the state Freedom of Information Law revealed numerous indications of fraud and abuse that the state had never looked into.

• "It's like a honey pot," said John M. Meekins, a former senior Medicaid fraud prosecutor in Albany who said he grew increasingly disillusioned before he retired in 2003. "It truly is. That is what they use it for."
What Does Fraud Look Like?

- June 4, 2012: Conn. Attorney General George Jepsen named 28 individuals, dental practices and corporations in a civil action on Thursday, alleging an elaborate and illegal two-year, $24 million Medicaid fraud scheme.

  Jepsen's suit alleges that the providers violated the Connecticut False Claims Act and the Connecticut Unfair Trade Practices Act.

  Two men were arrested on federal criminal charges last week for their alleged involvement in the billing scheme.

  "This is the first case the state has initiated under the Connecticut False Claims Act," Jepsen said. "It gives the state the rightful ability to seek compensation for taxpayers from those who seek to abuse the system with false claims for reimbursements they are not eligible to receive."
What Does Fraud Look Like?

• In Arizona, two operators of a small community mental health clinic were sentenced for false statements relating to health care matters. They were each ordered to pay $40,000 in restitution.
  – The investigation revealed that they used a matrix of keywords in order to systematically create false progress notes to pass the Medicare carrier’s medical review. They also photocopied doctors’ signatures on plans-of-care to keep patients in the partial hospitalization program for extended periods of time.
What Does Fraud Look Like?

• In Idaho, a woman was ordered to pay $129,000 in restitution for conspiracy to commit health care fraud. The woman owned and was a therapist at a counseling center.
  – The woman and her co-conspirator submitted fraudulent claims to Medicaid for case management services they did not provide. In order to submit the fraudulent claims, Medicaid numbers were obtained from their friends, family, and neighbors.
Why Report Fraud & Abuse?

• ARS 36-2918.01. Duty to report fraud or abuse; immunity
  – A. All contractors, subcontracted providers of care and non-contracting providers shall notify the director or the director's designee immediately in a written report of any cases of suspected fraud or abuse. The director shall review the report and conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. If the findings of a preliminary investigation give the director reason to believe that an incident of fraud or abuse has occurred, the matter shall be referred to the attorney general.

• Arizona Administrative Code R9-22-511. Fraud or Abuse.
  – A contractor, provider, or non-provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse
Fraud & Abuse Warning Signs

- Medical chart information doesn’t match billings and encounters
- Treatment plans not supported by current diagnosis
- Services not supported by current treatment plan
- Services provided but not billed or encountered
- Missing or inadequate documentation or data.
- Duplicate billings or encounters
- Professionals or clinics demanding unusually quick payment
- Number of service units for a day exceed possible hours in the work day
Fraud & Abuse Warning Signs

- Identical medication dispensed for same patient for same period from multiple pharmacies and/or on multiple prescriptions
- Patients or staff asked to sign or date late documents or case notes
- Case notes posted late to files or signatures and dates added late
- Patient description of services different from case notes
- Irreconcilable audit or review findings
- Provider is found to be on an excluded provider list
- Pattern of complaints by patients, contractors, subcontractors, etc.
What is the False Claims Act?

- Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of $5,000 to $10,000 per false claim (plus inflation adjustment)
What is the False Claims Act?

• Title 31, U.S.C. § 3729 – 3733

• Any person who **knowingly** files a false claim for payment upon the Federal Government

• Is civilly liable to Federal Government for $5,000 - $10,000 + 3X the amount of damages + cost of recovery

• Contains actions that can be taken by a private person (Qui Tam actions)

• **Knowingly**: actual knowledge of information, deliberate ignorance of truth or falsity of information or reckless disregard of the truth or falsity of information

• **No proof of specific intent to defraud is required**
What is a Qui Tam?

• The False Claims Act contains *qui tam*, or whistleblower provisions. *Qui tam* is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds.
  – In compensation for the risk and effort of filing a *qui tam* case, the citizen whistleblower or "relator" may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A *qui tam* suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action.
What Are False Claims & Statements?

- Title 31, U.S.C. § 3802
- Any person who makes, presents, or submits or causes to be, a claim or statement that the person \textbf{knows} or has reason to know is:
  - False, fictitious or fraudulent, including false, written statements and written statements that omit material facts or is for payment for something not provided as claimed
- Is civilly liable to Federal Government for not more than $5,000 for each false claim or statement
- \textbf{Knows}: actual knowledge of information, deliberate ignorance of truth or falsity of information or reckless disregard of the truth or falsity of information
- Administrative action
- \textit{No proof of specific intent to defraud is required}
What is Federal Whistleblower Protection?

• Title 31, U.S.C. § 3730 (h)
• Employee protection.
• Protects employee from discharge, demotion, suspension, threats, harassment or any other manner of discrimination regarding employment.
• As a result of lawfully notifying officials of violations of the false claims law under Title 31, U.S.C. § 3730.
  – Note: While this offers a legal remedy, it does not prevent you from being discharged, demoted, suspended, threatened or harassed as a result of “whistle blowing.”
Understanding Fraud

The Fraud Triangle
Why do they do it?

Opportunity
(perception of success)

Pressure
(unshareable need)

Rationalization
(why it’s okay)

The element that the organization has the most control over

The elements that the organization has some control over
Reducing Opportunity

• Increase the perception of detection
  – Strong internal controls – policies & procedures
  – Everyone follows established internal controls
  – Evidence of strong organizational ethics
  – Effective audits, reviews and monitoring
  – Fraud hotline
    • The ability to report anonymously
    • Management support of reporting
  – Zero tolerance for fraud resulting in swift action
• Collectively, this is known at the internal control environment
Internal Control Environment

• The overall feeling or sense of an organization's commitment to preventing fraud and program abuse
  (Would a crook think they could get away with fraud or abuse?)
Our Goal

• There are some places that you just don’t do certain things. We want our organization and yours to be places where employees and contractors just don’t engage in fraud. It just wouldn’t be worth it.
QUESTIONS?

Thank you