Office of Compliance and Program
Integrity
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Supervisor Medical Review

Vision

Ensuring North Carolina's Medicaid Program delivers intended results

Mission

Protect the resources of DMA by reducing or eliminating fraud, waste and abuse through the NC Medicaid program

Values

- ➢ Accountability
- ➢ Integrity
- ➢ Collaboration
- ➢ Innovation
- ➢ Communication

➤ Federally mandated

➤ Prevent, identify, and investigate potential fraud, waste, and abuse within the Medicaid Program
  - In NC, Possible fraud is referred to NC Medicaid Investigations Division (AGO/MID)

➤ Ensure Medicaid funds utilized appropriately
  - PI identifies and investigates for possible payment error, overutilization, medically inappropriate services

➤ Protect the "Integrity" of the Medicaid Program

Authority

➢ North Carolina General Statute 108C

➢ Medicaid State Plan

➢ North Carolina Administrative Code (NCAC)

➢ State Clinical Policies and Bulletin Articles

What is Fraud?

<u>Intentional</u> 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.

Credible allegation of fraud.

A credible allegation of fraud may be an allegation, which has been verified by the State, from any source.

Example

❖ Willfully / intentionally billing for services that are not provided

Credible allegation of /or suspected fraud

Referral to the NC Medicaid Investigations Division

➡ Potential for suspension of payments

➡ Potential for prepayment review

➡ Potential administrative sanctions affecting continued participation if supported by regulations

Fraud is...

Punishable in criminal court

→ Providers can be convicted often serve jail time.

What is Abuse?

➢ Provider practices that are **inconsistent** with sound fiscal, business or medical practice and result in an unnecessary cost to the Medicaid program.

➢ Also includes recipient practices that result in unnecessary cost to the Medicaid program

Example of Abuse*:*

A provider may be billing separately for items that should be bundled into one supply package.

What is the difference between fraud and abuse?

- In a case of abuse the **intention to deceive** is missing.

Program Abuse

If findings limited to Program Abuse, potential outcomes can include seeking recovery of overpayment(s), prepayment review

Program Integrity Responsibilities

➡ Receiving complaints and referrals

➡ Conducting preliminary investigations of suspected provider fraud, waste, program abuse or noncompliance

➡ Detecting/identifying potential provider fraud, waste and program abuse,

Referral Source…

➡ Complaints

   Beneficiaries, public, providers, employees

➡ Referrals from formal sources

   State and Federal Agencies

Pre-Payment Review

o **Purpose** is to ensure that Provider's claims meet the requirements of federal and State laws / regulations and medical necessity criteria

   For any claims in which the Department has given prior authorization, prepayment review shall not include review of the medical necessity for the approved services.

o Provider claims may be subject to prepayment review due (but not limited) to:

   → Credible allegation of fraud
   → Identification of aberrant billing practices as a result of data analysis or investigations, or
   → Other grounds as listed by the Department in rule.

   NCTRACKS: Electronic claim is routed to PI Prepayment Review contractor for manual review prior to payment

Pre-Payment Review

➡ <u>Provider Notice of Prepayment Review Must Occur</u> no less than 20 calendar days prior to initiating prepayment review.

➡ The notice of prepayment review will include:
- the reason (s) for prepayment review,
- the type of claims (may be limited to certain code) subject to review & include standards by which claims are reviewed
- include process explanations, provider instructions & explain claim review time frames
- which records are requested, how to submit and time limits for submission

Pre-Payment Review

Similar to the Desk Review

Pre-Payment reviewer receives Provider's supporting documentation and:

    a) Determines if Provider submitted entirety of requested records

    b) Makes determination whether Provider's documentation supports claim details

    c) Makes determination whether Provider's documentation supports program compliance

    d) Reviews clinical coverage policy applicable to DOS under review

    e) Applicable laws, regulations

Most Common Pre Payment Errors Found

➡ Licensing/Training/Credentialing Requirements

- • Staff Credentials
- • Staff Training
- • Staff Background Verification
- • Staff Competency Verification
- • Supervisory notes to support policy requirements

➡ Not following Current DMA policy

Outcome of a Review

Violations of Participation Agreement, Program Abuse, Failing to Meet Prepayment Review Accuracy Threshold:

➡ Provider not operating in accordance with (or violations of) terms of Medicaid Participation Agreement (includes falsification of enrollment application)

➡ Provider not licensed/qualified per Medicaid / Health Choice requirements

➡ Failure to meet minimum prepayment review accuracy threshold of at least 70% for three consecutive months on pre-payment review

Post Payment Review

Onsite Announced:

- Provider is given advance notification of PI site visit via fax, telephone call, email (# days advance notice may vary per scope of review)

Onsite Unannounced:

- PI or Post Pay Contractor arrives on day of review to Provider site (no prior fax, letter, phone call or email)
- Introductory Discussion with Provider Management
- Staff Introduction & Introductory "Letter"
- Medical Records Request
- Intro to Provider files & setup of PI Staff
- Exit discussion per Scope of Review
  Goal = Be As Minimally Disruptive as Possible

Desk Review:

- Provider is notified of review via written request for records

- Time Frame and Instructions for Submission

- PI or Contractor Contact

- General Description of Matters Subject to Review

- Currently Most Frequent Method of Post Pay Review

  Note: Certified Mail is most frequent method of contact. PI uses **correspondence address listed in NCTRACKS**

Most Common Post Payment Errors Found

Credentialing and Training
- ➡ Criminal Background checks not done or done months after hiring
- ➡ Failure to check the Health Care Registry
- ➡ No documentation of completing skills competency prior to date of service

Not following current DMA policy

Outcome of a Review

1. No errors, may close case

2. Payment error less than $150.00 may receive an educational letter

3. May recommend training

4. Overpayment identified

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