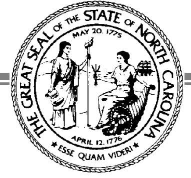
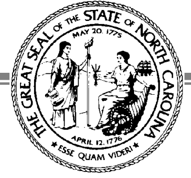


Division of Medical Assistance
Program Integrity Unit

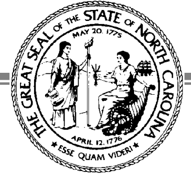
north carolina medicaid

Program Integrity Unit



- Federally mandated
- Prevent, identify, and investigate potential fraud, waste, and abuse within Medicaid
  - Possible fraud is referred to NC Medicaid Investigations Division
- Ensure Medicaid funds utilized appropriately

Program Integrity Unit

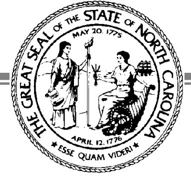


- Implement remedial measures
  - Prepayment review
- Administrative actions to address aberrancies/overpayments/abuse
  - Request recovery of overpayments
- Ensure recipients receive quality care and do not abuse their benefits

Program Integrity Mission

Ensure compliance, efficiency*, and* ***accountability*** *within the N.C. Medicaid Program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupments, and identifying avenues for cost avoidance.*

Program Integrity Authority



Federal

- Code of Federal Regulations (Title 42 Public Health)
- Social Security Act Amendments
- Affordable Care Act

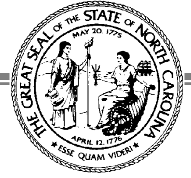
State

- North Carolina General Statutes
- Medicaid State Plan
- North Carolina Administrative Code (NCAC)
- State Clinical Policies and Bulletin Articles

Federal Fraud and Abuse Laws

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Statute
- Exclusion Statute
- Civil Monetary Penalties

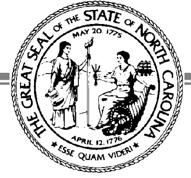
What is Fraud?



Fraud : 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.

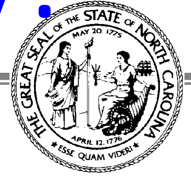
What is Abuse?



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

It also includes recipient practices that result in unnecessary cost to the Medicaid program

Who is DMA Program Integrity?



Behavioral Health

Special Projects

Provider Medical

Program Integrity

Quality Assurance

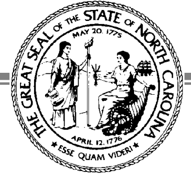
Home Care

Business Operations

Business Intake Center

Organized into Sections (circles in the diagram) and Interface with other sections (octagons in the diagram) in DMA and DHHS

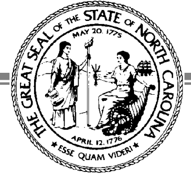
PI Investigative Sections



Behavioral Health Review Section

- Provider types include but are not limited to:
  - outpatient behavioral health
  - community support teams
  - enhanced in home services
  - CAP MR/DD
- Continually work with MCOs to assure PI functions are performed in accordance with state and federal law

PI Investigative Sections

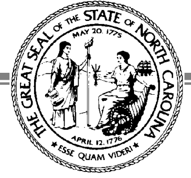


Provider Medical Review and Pharmacy

Provider types:

Nursing facilities	Health departments
Physician and physician-type providers	Federally qualified health clinics
Ambulatory surgery centers	Rural health clinics
Hospitals	Ambulance
Dialysis facilities	Laboratory
Pharmacy	Radiology

PI Investigative Sections



Home Care Review Section

Provider types include, but are not limited to:

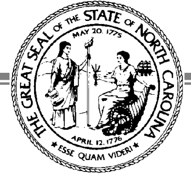
- Home Health and Hospice
- Dentists
- Durable Medical Equipment
- Private Duty Nursing
- Personal Care Services
- Independent Practitioners
- Community Alternatives Program (CAP) for Disabled Adults and for Children
- HIV Case Management
- Home Infusion Therapy and Adult Care Homes

PI Investigative Section Resources

NCTracks and specialized software to detect/verify possible billing anomalies & investigative leads

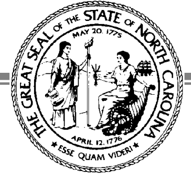
- IBM FAMS
- IBM Identity Insight
- Truven JSURS
- NCTracks
- Advantage Suite
- Data Warehouse (SAS)

PI Contractors



- Public Consulting Group (PCG)
  - Post payment reviews
- Health Management Systems (HMS)
  - Post payment reviews
  - RAC
- Carolinas Center for Medical Excellence (CCME)
  - Prepayment review

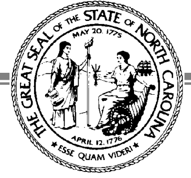
Other PI Sections



Business Intake Center

- Receives calls and web inquiries of complaints related to Medicaid fraud, waste or abuse
- Places all relevant information in the PI Case Tracking System, retrieves provider data from NCTracks and also billing data
- Forwards all relevant information to PI Sections for further review and disposition

Other PI Sections



Quality Management Services

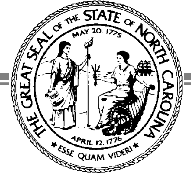
Contains 2 components:

- Special Projects and
- Quality Control

Special Projects

Manages and coordinates the North Carolina federal and state mandated program integrity reviews, i.e. Payment Error Rate Management (PERM), etc.

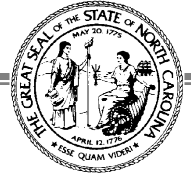
Other PI Sections



Quality Assurance Section

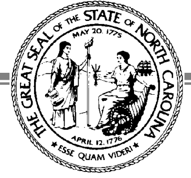
- Develops and implements policies and procedures for recipient fraud and abuse
- Coordinates recipient fraud investigations with the county departments of social services

PI Investigations & Reviews



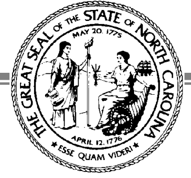
- Post Payment Review
  - Onsite announced or unannounced
  - Desk
- Prepayment Review
  - Remedial measure
- Provider Self Audits
- Special Audits
- Targeted or Routine Reviews

PI Referral Sources



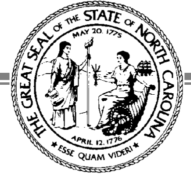
- Complaints
  - Beneficiaries, public, providers
- Referrals from formal sources
  - Regulatory agencies, DSS, DHHS partners, DMA program consultants, CMS, OSA
- Data analysis
  - Federally mandated

The PI Investigation



- Onsite: Investigation Notification*, Introductory Letter & Records Request
- Desk: Medical Records Request
  - Prepayment review = Desk Reviews
- Confidential
- Provider Response/Cooperation
- Prepay: Time Sensitive! Records Review for Each Claim
  - Providers Receive Instructions and PI Contact Information on Records Requests

The PI Investigation



Investigative Findings

- No Errors
- Overpayment Determinations
- Claim Denial (Prepayment Only)
- Administrative Sanctions
- Referrals (such as AGO/MID, Regulatory agencies)
- All Adverse Actions* Subject to Reconsideration Reviews
  - Providers receive instructions and PI contact information on PI Correspondence

The PI Review Tool/Questionnaire

- Ensure consistency of review
- Interpretive guidance
- Based on program requirements
- Adaptable to automation
- Review questionnaires may vary by audit, such as OSA, Hospital Inpatient

The PI Review Tool/Questionnaire

Q1: Services Authorized/Approved in Accordance with Program Requirements

- How are the services authorized according to the Medicaid/Health Choice coverage policy?
  - MD Order/Prescription
  - Case Manager (CAP) Authorization
  - Prior Approval (for PCS, PA from the IAE)
  - EPSDT
- Was there an order/approval/authorization in place on the date of service under review?

The PI Review Tool/Questionnaire

Q2: Documentation Supports Billed Codes/Modifiers/ Claim Details.

- Reviewers refer to the Medicaid/Health Choice coverage policy to verify
  - Procedure codes & (if applicable) modifiers
  - Whether or not policy requires specific content, forms/formats for documentation
  - Program requirements for billing quantities (such as a “unit” or a “day”)
- Does the provider’s documentation support the billed claim details and reflect the policy instructions/requirements?
  - Date, quantity, MID, location
  - Procedure codes & modifiers
  - Provider used required forms/formats (if applicable)

The PI Review Tool/Questionnaire

Q3: Licensing/Training/Credentialing Requirements Met

- Refer to the Medicaid/Health Choice coverage policy to determine:
  - Provider licensing requirements (such as DHSR license for home care agency)
  - Credentialing/Licensing requirements for direct care staff and/or supervisors
  - Program requirements for staff training
  - Program requirements for staff background checks/other verification
- Does provider's documentation support the provider agency and/or its staff appropriately licensed/qualified/trained/credentialed?

The PI Review Tool/Questionnaire

Q4: Required/Covered Components of Service Completed/Provided in Accordance with Policy

- Refer to the Medicaid/Health Choice coverage policy to determine:
  - Required components such as Plans of Care/Service Plans, Supervision, Assessments/Reassessments, Limits, Frequencies, etc.
  - “Covered” components, which vary by program and may not be provided to all beneficiaries
- Does provider documentation support that the required or covered components were completed/provided/documented per policy ?

The PI Review Tool/Questionnaire

Q5: Documentation Supports Services Appropriate for Beneficiary Needs

- Refer to Medicaid/Health Choice policy to determine:
  - Minimum coverage or “medical necessity” criteria & how determined
  - EPSDT instructions
  - What’s covered, non-covered, eligible beneficiaries, settings, etc.
  - What is considered a “duplication” of services
- Does provider documentation support:
  - Services billed per orders, authorization, PA?
  - Services provided per Plan of Care/Service or Treatment Plan
  - Services did not appear to exceed needs

What Does PI Mean to Providers?

Providers may

- Meet PI Staff in Person during onsite Audits; educational sessions; hearings
- Receive E-Mail from PI regarding requests for documentation; notifications of under or overpayments; educational letters
- Talk with PI Staff on the phone to call in a complaint; discuss an audit; ask a question

Questions?