EARLY INTERVENTION PROGRAM FOR INFANTS AND TODDLERS WITH DISABILITIES-MEDICAID COMPLIANCE

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2011

- GOVERNOR CUOMO'S STATE OF THE STATE (January 5, 2011):
  - MEDICAID AS ONE OF THREE PRIMARY FOCUS AREAS
  - NOT BUDGET CUTTING OR TRIMMING, BUT - REINVENTING, REORGANIZING, AND REDESIGNING PROGRAMS AND AGENCIES
  - MEDICAID REDESIGN TEAM
  - REQUIRES THOROUGH REVIEW OF MEDICAID PROGRAMS AND AGENCY PRACTICES
  - ON-TIME BUDGET 2011

PURPOSE OF OMIG WEBINARS- FULFILLING OMIG'S DUTY IN NYS PHL SECTION 32 -

- § 32(17) **" . . . to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program."**
- **These programs will be scheduled as needed by the provider community. Your feedback on this program, and suggestions for new topics are appreciated.**
- **Next program: Preschool/School Supportive Health Services Program (SSHSP) Medicaid-in-Education**

GOALS OF THIS PROGRAM

- Education for Medicaid providers and municipal/county governmental entities on compliance with Medicaid payment requirements
- Federal funding brings federal oversight-provider and municipality responsibilities under Medicaid
- Responsibilities of OMIG and DOH
- Audit process and approach

CONCERNS OF THIS PROGRAM

- Complexity of Early Intervention rules-, Medicaid, Private Insurance, Education
- Complexity of Early Intervention reimbursement- Medicaid, state/county, (through localities and state general fund) private
- Not a choice-counties obligated to assure provision of early intervention services, obligated to address billing and payment issues

EARLY INTERVENTION-MEDICAID

- Total Medicaid EI expenditures in NY $262 million (2010)
- Federal share $131 million
- NY City=$205 million total expenditures

Early Intervention – for “infants and toddlers with disabilities”

- (1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:
  - (i) Cognitive development.
  - (ii) Physical development, including vision and hearing.
  - (iii) Communication development.
  - (iv) Social or emotional development.
  - (v) Adaptive development;

- (2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay

THE EARLY INTERVENTION PROGRAM FEDERAL LAW AND REGULATIONS

- *Individuals with Disabilities Education Act*, Part C, Sec. 631, as amended; 20 U.S.C. 1431 et seq.

- 34 CFR 303
  Available:
  http://www2.ed.gov/programs/osepeip/legislation.html

EARLY INTERVENTION STATE LAW AND REGULATIONS

- Title II-A of Article 25 of the Public Health Law
- Subpart 69-4: Regulations for the Early Intervention Program (10 NYCRR Part 69-4)
- http://www.health.state.ny.us/community/infants_children/early_intervention/regulations.htm

CORE MEDICAID REQUIREMENTS 18 NYCRR 504.3 FOR ALL PROVIDERS

- Medicaid is payment in full-no balance billing
- Bill for only services which are medically necessary and actually furnished
- Bill only for services to eligible persons
- Permit audits. . . of all books and records relating to services furnished and payments received, including patient histories, case files, and patient-specific data
- Provide information in relation to any claim . . . Which is true, accurate, and complete.
- “to comply with the rules, regulations, and official directives of the department.”

WHO MAY AUDIT MEDICAID EARLY INTERVENTION PAYMENTS?

- Office of Medicaid Inspector General (NY)
- HHS and Education Office of Inspector General (federal)
- Medicaid Fraud Control Unit (NY)
- Medicaid Integrity Contractor (CMS)
- NYS Department of Health fiscal audits, which may include a site visit, of all or any of the following: municipalities, service coordinators, evaluators, or providers of early intervention services. (also performed by contractors)
- Office of State Comptroller (NY)
- Counties and County Comptrollers
- GAO

OTHER AUDIT/INVESTIGATIVE RISKS

- New York Attorney General actions under the New York False Claims Act
- Whistleblower actions under the New York False Claims Act (these cases limited to private entities)
- Claims under the federal False Claims Act

WHO MAY BE AUDITED?

- Municipality (county) submitting claim
- Contracted provider of services
- Service bureau, billing service, or electronic media billers preparing or submitting claims (See 18 NYCRR 504.9)

Federal HHS OIG AUDIT 2010 - Review of Early Intervention Services Costs Claimed by New Jersey to the Medicaid Program

- the child receiving the related service was enrolled in the Medicaid program;
- the related service was covered under the program;
- the related service was listed in the child's treatment plan (Individualized Family Service Plan); and
- the State agency paid the claims within 1 year of the date of receipt.
- http://oig.hhs.gov/oas/reports/region2/20801019.pdf

RESULT OF 2010 HHS/OIG AUDIT OF NEW JERSEY

- Claims for early intervention submitted as a result of New Jersey's "contract with Covansys did not always comply with Federal and State regulations. Of the 100 claims in our random sample, 94 complied with Federal and State requirements, but 6 did not. Of the six noncompliant claims, two claims contained services that were not provided or supported, and four claims were not timely submitted. These deficiencies occurred because the State did not effectively monitor the early intervention program for compliance with certain federal and state requirements."

- http://oig.hhs.gov/oas/reports/region2/20801019.pdf

WHAT YOU HAVE PROMISED TO DO

- Application for Approval of Individual Evaluators, Service Providers and Service Coordinators
- DOH-3735(3/05)
- Codified in 10 NYCRR 69-4.5
- Re-application process not yet implemented

WHAT YOU HAVE PROMISED (AND WE CHECK)

- Attest to character and competence; (how determine?)
- Assure the maintenance of current state licensure and/or certification and demonstrated proficiency in early childhood development
- Assure that he/she will notify the Department within two working days of suspension, expiration, or revocation of licensure, certification or registration;
- Participate in in-service training or other forms of professional training and education related to the delivery of early intervention services;
- Agree to enter into an approved Medicaid Provider Agreement and to reassign Medicaid benefits to the local county early intervention program or City of New York early intervention program;
- Assure compliance with the confidentiality requirements set forth in regulation.
- **DOH-3735(3/05)** 10 NYCRR 69-4.5

WHAT YOU HAVE PROMISED

- **Keep any records necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance;**

- **On request, furnish the New York State Department of Health, or its designee, and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A) (1), and any information regarding any Medicaid claims reassigned by the Provider to the local early intervention agency;**

- **Abide by all applicable Federal and State laws and regulations, including the Social Security Act, New York State Social Services Law, part 42 of the Code of Federal Regulations and Title 18 of the Codes, Rules and Regulations of the State of New York**

- **DOH-3735(3/05)** 10 NYCRR 69-4.5

Limiting fraud and abuse within the Medicaid program

- "Fraud means an **intentional deception or misrepresentation** made with the knowledge that the deception could result in an unauthorized benefit to the provider or another person . . ." 18 NYCRR 515.1

Limiting fraud and abuse within the Medicaid 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-similar provision in state regulations 18 NYCRR 515.1 (b)

- "Abuse" does not require intentional conduct-it is measured by objective measures
  - –Medically unnecessary care
  - –Care that fails to meet recognized professional standards
  - –"provider practices that are inconsistent with sound fiscal . . .practices"
  - –failing to bill other payors

THE SIX GREATEST MEDICAID PROGRAM RISKS IN EI

- RISK #1: Using excluded persons to provide services reimbursable by Medicaid.
- RISK #2: Failing to refund identified overpayments to the Medicaid program.
- RISK #3: Failing to maintain an “effective” compliance program as required by 18 NYCRR 521 (if over $500,000).
- RISK #4: Failing to require and maintain records demonstrating medical necessity (as shown by authorization) , authorization, and actual performance of a reimbursable service.
- RISK #5: Failing to supervise service bureaus or billing companies submitting claims or receiving payment.
- RISK #6: Failing to assure proper payment by third parties before Medicaid.

RISK #1: Using Excluded Persons to Provide Services Reimbursable by Medicaid

- See OMIG's Exclusion Webinar on our website at http://www.omig.ny.gov/data/images/stories/Webinar/6-8-10_exclusion_webinar_final.ppt

Program Exclusions

- Statute
- Regulation
- Federal OIG Guidance
- Federal CMS Guidance
- State Guidance Mandated by CMS
- Condition of NY provider enrollment or NY state contract
- Virtually no case law (criminal, civil, or administrative) on extent and effect of exclusion

CMS EXCLUSION REGULATION

- "No payment will be made by Medicare, Medicaid or any of the other federal health care programs for any item or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion." 42 CFR 1001.1901 (b)
- Focus is not on the relationship but on the **payment.**

PROGRAM EXCLUSION

- Federal authority and requirement on providers
  - No claims based on work of excluded persons
- Federal authority and mandate on state Medicaid programs
  - No state Medicaid claims to CMS based on work of excluded persons

Impact of Exclusion on Health Care Providers

- Once exclusion occurs, health care providers:
  - May employ or contract with excluded persons, but may not allow excluded persons to provide or to direct the ordering or delivery of services or supplies, or to undertake certain administrative duties (IFSP team evaluator, service providers, service coordinators, local early intervention official)
  - Whether or not direct care activities are involved
  - If any part of the task is reimbursed by federal program (Medicaid) dollars
  - Note: Staffing agencies must screen potential candidates to ensure that they have not been excluded prior to being sent to providers for work. Providers must develop and enforce contractual agreements to ensure prescreening occurs.

THE NEW YORK STATE EXCLUSION REGULATION

- **18 NYCRR 515.5** Sanctions effect: (a) No payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion or in violation of any condition of participation in the program.

RISK #2: Failing to Refund Identified Overpayments to the Medicaid Program- ACA § 6402

- *"(d) REPORTING AND RETURNING OF OVERPAYMENTS—*
- *"(1) IN GENERAL — If a person has received an overpayment, the person shall—*
- *"(A)* **report and return the overpayment** *to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate,* **at the correct address***; and*
- *"(B)* **notify the** *Secretary,* **State***, intermediary, carrier, or contractor* **to whom the overpayment was returned in writing of the reason for the overpayment . . .**

ACA § 6402 and False Claims Act

- Failure to report, refund, and explain overpayments within 60 days of identification can give rise to a claim of "knowing" failure to repay under the False Claims Act
- See OMIG Webinar: http://www.omig.ny.gov/data/images/stories/Webinar/7-14-10_ppaca_webinar.ppt

RETURNING OVERPAYMENTS IN NEW YORK TO THE MEDICAID PROGRAM

- **Report and return the overpayment *to the State* at the correct address**
- **In New York, Medicaid overpayments should be returned, reported, and explained to OMIG**
- **OMIG's correct address:**
  - **Office of the Medicaid Inspector General**
  - **800 North Pearl Street**
  - **Albany, New York 12204**
- **May also use DOH adjustment process for multiple funders through Brad Hutton (BJH08@Health.State.NY.US)**

VOIDS AND SMALL OVERPAYMENTS

- **Providers may use void process through CSC (the eMedNY claims system) for smaller or routine claims. A void is submitted to negate a previously paid claim based upon a billing error or late reimbursement by a primary carrier.**
- **Overpayments of smaller or routine claims which cannot be attributed to billing error or late reimbursement by a primary carrier should be reported to CSC in writing. These should include known mistakes in CSC or DOH billing and payment programs.**
- **eMedNY call center: 1-800-343-9000, M – F, 7:30 am – 6:00 pm; email: HIPAADESK3@csc.com**
- **See http://www emedny.org/provider manuals for instructions on submission of voids.**
- **NYEIS System also can be used to initiate report and refund process**

WHAT IS AN "OVERPAYMENT"?

- "(B) OVERPAYMENT—The term "overpayment" means any **funds** that a **person** receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title"
- "**funds**" not "**benefit**"

WHO MUST RETURN THE OVERPAYMENT?

- A “person” (which includes corporations and partnerships) who has “received” or “retained” the overpayment
- Focus on “receipt”; payment need not come directly from Medicaid; if “person” “retains” overpayment due the program, violation occurs
- “person” includes a an individual program enrollee or subcontractor as well as a program provider or supplier
- Is a state agency a “person”? Vermont v. US 529 U.S. 765 (2000); is local government a state agency? Cook County v. US 123 S. Ct. 1239 (2003)

WHEN MUST AN OVERPAYMENT BE RETURNED?

- ACA § 6402(d)(2)

- An overpayment must be reported and returned . . .by the later of -
  - (A) the date which is 60 days after the date on which the overpayment was **identified**; or
  - (B) the date on which any corresponding cost report is due, if applicable

WHEN IS AN OVERPAYMENT "IDENTIFIED"?

- "identified" for an organization means that the fact of an overpayment, not the amount of the overpayment has been identified. (e.g., patient was dead at time service was allegedly rendered, APG claim includes service not rendered, charge master had code crosswalk error)

- Compare with language from CMS proposed 42 CFR 401.310 overpayment regulation 67 FR 3665 (1/25/02 draft later withdrawn)
  - "If a provider, supplier, or individual identifies a Medicare payment received in excess of amounts payable under the Medicare statute and regulations, the provider, supplier, or individual must, within 60 days of identifying or learning of the excess payment, return the overpayment to the appropriate intermediary or carrier."

WHEN IS AN OVERPAYMENT "IDENTIFIED"?

- Employee or contractor identifies overpayment in hotline call or email
- Patient advises that service not received
- RAC advises that dual eligible Medicare overpayment has been found
- OMIG sends letter re deceased patient, unlicensed or excluded employee or ordering physician
- *Qui tam* or government lawsuit allegations
- Criminal indictment or information

DOCUMENTING GOOD FAITH EFFORT TO IDENTIFY OVERPAYMENTS

- Create a record to demonstrate to the government that your organization collected or attempted to address allegations of overpayments
  - Develop standard form to document employee's internal disclosure
  - Document interviews
  - Document evidence and means to determine if credible
  - Record employees involved in deliberations and decisions

SOME REASONS FOR OVERPAYMENTS

- Duplicate payments of the same service(s).
- Incorrect provider payee.
- Payment for services not authorized on IFSP.
- Services not actually rendered.
- Payment made by a primary insurance.
- Payment for services rendered during a period of non-entitlement (transition out of program).

MORE REASONS FOR OVERPAYMENTS

- Failure to refund credit balances
- Excluded ordering or servicing person
- Patient deceased
- Servicing person lacked required license or certification (e.g., CFY speech students beyond period of approved supervision)
- Billing system error

GOVERNMENT IS USING DATA TO DETECT OVERPAYMENTS

- EXCLUDED PERSONS
- DECEASED OR TRANSITIONED ENROLLEES
- DECEASED PROVIDERS
- CREDIT BALANCES
- WHAT IS GO-BACK OBLIGATION WHEN PROVIDER IS PUT ON NOTICE THAT SYSTEMS ARE DEFICIENT?

“OVERPAYMENT” INCLUDES:

- PAYMENT RECEIVED OR RETAINED FOR SERVICES ORDERED OR PROVIDED BY EXCLUDED PERSON “no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by an excluded individual or entity or at the medical direction or on the prescription of a physician or other authorized individual who is excluded . . .” 42 CFR 1001.1901

OMIG DISCLOSURE GUIDANCE

- "OMIG is not interested in fundamentally altering the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims."

OMIG SELF DISCLOSURE FORM FROM WWW.OMIG.NY.GOV

- You must provide written, detailed information about your self disclosure. This must include a description of the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s), the period involved, the person(s) involved, the legal and program authorities implicated, and the estimated fiscal impact. (Please refer to the OMIG self-disclosure guidance for additional information.)

RISK #3: Failing to Maintain an "Effective" Compliance Program as Required by 18 NYCRR 521 (if billing over $500,000 per year)

- See OMIG Webinar: Evaluating Effectiveness of Compliance Programs
- http://www.omig.ny.gov/data/images/stories/Webinar/compliance_webinar_11-17-10.ppt

Maintaining an “Effective” Compliance Program

- 18 NYCRR 521
- Requires an 8 step effective compliance program
- Requires an annual certification by December 31 of each year
- Applies to both governments and providers (directly or indirectly)

NY Mandatory Compliance Program- Prior to ACA

- NY Medicaid law and regulation: every provider receiving more than $500,000 per year must have, and certify to, an effective compliance program with eight mandatory elements. 18 NYCRR 521
- Statute – November 2006; Regulation – 7/1/09
- Mandatory compliance includes
  - Audit program,
  - Disclosure to state of overpayments received, when identified (over 80 disclosures in 2009)
  - Risk assessment, audit and data analysis
  - Response to issues raised through hotlines, employee issues
- Effective program required by 10/1/09
- Certification of effective compliance program – 12/31/09
- Evaluation - ongoing

RISK #4: Failing to Require and Maintain Records Demonstrating IFSP Approval, Authorization, and Actual Performance of a Reimbursable Service

- Documentation requirements specific to Early Intervention set forth at :
- http://www.health.state.ny.us/community/infants_children/early_intervention/memo03-1.htm#_toc41982738; 10 NYCRR 69-4.26

DOCUMENTATION SUBMISSION REQUIREMENTS FROM PROVIDERS TO MUNICIPALITIES FOR MEDICAID BILLING

- Recipient identification (name, sex, age).
- Unit of service (e.g., home and community/facility-based, etc.) and specific type of service provided.
- Date(s) service was rendered.
- ICD-9 diagnostic code (until 10/1/2013, then ICD-10)
- CPT code for delivered services.
- Name, address and license number of contracting individual professional
- Name and identifying information of the early intervention provider and individual licensing information

DOCUMENTATION MAINTENANCE AND RETENTION REQUIREMENTS FOR MEDICAID BILLING

- Name and license, certification, or registration number (current as of the date of service) of the professional who directly delivered the diagnostic or treatment service.
- A copy of the Individualized Family Service Plan (IFSP). (current as of the date of service)
- Authorization from the municipality to deliver the service. (current as of the date of service)
- Written orders or recommendations from specific medical professionals when required for the services being provided.
- **Early Intervention Memorandum 93-2 (Reissued with no Change** December 2000) available at http://www.nyhealth.gov/guidance/oph/cch/bei/ ; 10 NYCRR 69-4.26

Risk #5: Failing to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- See OMIG Webinar-Third Party Billing in the Medicaid program
- http://www.omig.ny.gov/data/images/stories/Webinar/1-12-11_third_party_billing_final.ppt

Duty to Supervise Service Bureaus or Billing Companies Submitting Claims or Receiving Payment

- Who is responsible if the billing company makes a mistake?
- the person or entity on behalf of whom the claim is submitted.

Questions for Health Care Providers About Third-Party Billers

- If any non-employee submits your claims, checks enrollment, or obtains authorizations, have you received a written representation that the person or entity has a records preservation policy consistent with EMEDNY-414601 (i.e., six years from the date of claims submission) for material and data your organization submits, and 10 NYCRR 69-4.26 requirements (to age 21 for educational records)?

"Compliance Program Guidance for Third-Party Medical Billing Companies," 63 FR 70138-70152 (December 18, 1998)

- billing for items or services not actually documented;
- unbundling and upcoding of claims;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits;
- billing company incentives that violate the anti-kickback statute;
- percentage billing arrangements.

New York State Regulation- Required enrollment

- “Persons submitting claims, verifying client eligibility, . . . Except those persons employed by providers enrolled in the medical assistance program, must enroll in the medical assistance program. . . “ 18 NYCRR 504.9
- Is your billing company enrolled?

RISK #6: Failing to Assure Proper Payment by Third Parties Before Medicaid

- Ongoing disputes with insurors about coverage
- Guidance Document on Claiming Commercial Insurance for Early intervention Guidance Document 2003-2

Additional Medicaid Program Integrity ACA Requirements: ACA § 6401– Provider Screening & Disclosure Requirements

- Applicants/providers re-enrolling would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked.

Additional Medicaid Program Integrity ACA Provisions

- STATE REQUIREMENTS:
- § 6501 – Termination of Provider Participation
  - States are required to terminate individuals or entities from Medicaid programs if individuals/entities were terminated from Medicare or other state plan under same title.
- § 6502 – Exclusion Relating to Certain Ownership, Control and Management Affiliations
  - Exclude if entity/individual owns, controls or manages an entity that: (1) failed to repay overpayments, (2) is suspended, excluded or terminated from participation in any Medicaid program, or (3) is affiliated with an individual/entity that has been suspended, excluded or terminated from Medicaid.
- ALTERNATE PAYEE REQUIREMENTS:
- §6503 – Billing agents, clearinghouses, or other alternate payees that submit Medicaid claims on behalf of health care provider must register with State and Secretary in a form and manner specified by Secretary

CONCLUSION: THE THREE MOST IMPORTANT MEDICAID INTEGRITY PROVISIONS OF ACA

- 1. MANDATORY REPORTING AND REPAYMENT OF OVERPAYMENTS BY "PERSONS"
- 2. RETENTION OF OVERPAYMENT IS A FALSE CLAIM (invokes penalties and whistleblower provisions)
- 3. MANDATORY COMPLIANCE PLANS

UPCOMING WEBINAR INFORMATION

- April Webinar- Preschool/School Supportive Health Services Program (SSHSP) Medicaid-in-Education
- Previous Webinars (www.omig.ny.gov)
  - Excluded parties
  - Self disclosures, overpayments
  - Effective compliance program and whistleblower issues, evaluating effectiveness of compliance programs
  - Third-party billing

FREE STUFF FROM OMIG

- OMIG website - www.OMIG.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over $500,000/year
- Over 1500 provider audit reports, detailing findings in specific industry
- 66-page work plan issued 4/20/09 - shared with other states and CMS, OIG (new one coming in July, 2010)
- Listserv (put your name in, get emailed updates)
- New York excluded provider list
- Follow us on Twitter: NYSOMIG