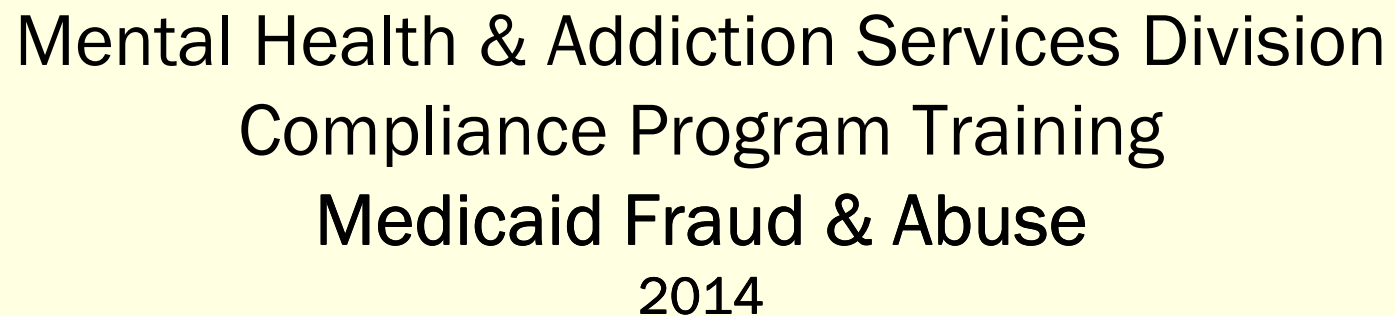





# Multnomah County Department of County Human Services



Mental Health & Addiction Services Division  
Compliance Program Training  
Medicaid Fraud & Abuse  
2014

# Training Objectives

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THIS TRAINING DOES NOT LIMIT THE AUTHORITY OF DHS OR ANY OTHER HEALTH OVERSIGHT AUTHORITY FROM PURSUING LEGAL RECOURSE TO THE FULL EXTENT OF THE LAW.

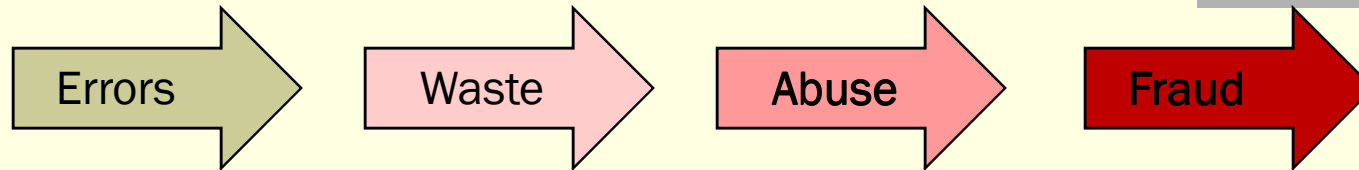
By the end of this presentation, you will be familiar with:

- Definition of Fraud and Abuse
- Medicaid Fraud and Abuse Laws
- Civil and Criminal Penalties
- Protections for Whistleblowers or “*qui tam* relators”
- Behavioral Health Risk Areas
- MHASD Compliance Plan
- Your Responsibilities

*Your understanding of these matters is critical to MHASD’s successful compliance plan. Please ask questions!!!!*

# What is the definition of Medicaid Waste, Fraud and Abuse?

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**Errors** happen when a provider makes a mistake in service delivery, documentation, or billing. Some examples of errors may include selecting the incorrect service type for the service rendered; or selecting the incorrect time for the service. Errors are usually random and do not have a pattern to them.

**Waste** is spending that can be eliminated without reducing the quality of care, such as overuse, underuse and ineffective use of treatments or medications. It is also inefficiency in redundant testing, delays in treatment, and making processes unnecessarily complex. Generally waste is not considered to be criminally negligent actions but rather the poor use/misuse of resources.

# Medicaid Fraud

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**Fraud** is defined as making false statements or misrepresentation of facts in order to obtain some benefit or payment for which no entitlement would otherwise exist

It includes obtaining something of value through

- Misrepresentation or
- Concealment of material facts



# Medicaid Abuse

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**Abuse** is defined as practices that don't follow sound fiscal, business or medical practices and directly or indirectly

- Result in unnecessary costs,
- Are not medically necessary,
- Are not professionally recognized standards, and
- Are not fairly priced.

Both Fraud and Abuse can expose providers to criminal and civil liability.

# What are some examples?

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## Fraud

- Billing for any services not actually performed.
- Billing for a more expensive service than was actually provided.
- Ordering diagnostic tests or billing for services that are not medically necessary.
- Falsifying timesheets or signatures in connection with the provision of skills training or personal care services.

## Abuse

- Upcoding to longer or more complex services
- Routinely submitting duplicate claims or unbundling claims

## **September 30, 2013: Felony Medicaid Fraud Charges Against Four Southeast Michigan Mental Healthcare Providers**

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- **LANSING** - Attorney General Bill Schuette today announced felony charges against four licensed Southeast Michigan mental healthcare providers.
- It is alleged that the four mental healthcare providers forged the electronic signature of a former employee who left her employment without completing progress notes for hundreds of encounters with mental health patients. The four defendants allegedly falsified the incomplete progress notes to satisfy Medicaid program rules and avoid paying money back to the Medicaid program.

# Medicaid Fraud and Abuse Laws

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- The False Claims Act
- Fraud Enforcement and Recovery Act (2009)
- Patient Protection and Affordable Care Act (2010)
- U.S. Criminal Code

are all used to address fraud and abuse.

**Violations of these laws may result in**

- Nonpayment of claims
- Civil Prosecution & Financial Penalties
- Criminal Conviction/Fines
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs





# False Claims Act

## 31 United States Code § 3729-3733

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Protects the Government from being overcharged or sold substandard goods or services

Imposes Civil Liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government

May include **fin**es of not less than \$5,500 and not more than \$11,000, (currently) **plus** 3 times the amount of **damages** which the Government sustains because of the act of that person.

### Identifies types of conduct that create a False Claim:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government or certifying receipt of property without knowing if it's true;
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

# False Claims Act continued:

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## The knowledge requirement

The terms “knowing” and “knowingly” mean that a person

- (1) acts in deliberate ignorance; or
- (2) acts in reckless disregard of the truth related to the claim.

- **No proof of specific intent to defraud is required.**

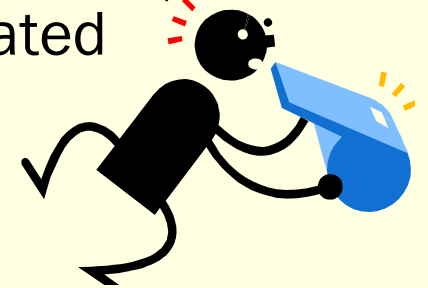
In sum, the False Claims Act imposes a civil liability on any person who may submit a claim to the federal government that he or she knows (or should know) is false.



# Protections for Whistleblowers also called “*qui tam* relators”

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- Private parties (“qui tam” relators) may bring an action on behalf of the government under the False Claims Act.
- The relator does not have to be personally harmed by the actions they are reporting. In most cases, the action is based on the relator’s direct and independent knowledge of the wrongdoing. Most relators are employees, former employees, competitors or contractors.
- The False Claims Act provides protection to relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA.  
31 USC 3730(h).



# Federal Civil & Criminal Penalties for False Claims

<b>31 USC Chapter 38</b>	Administrative remedies for false claims and statements / Collection of civil penalties
<b>42 USC 1320a-7b(b) Anti-Kickback Statute</b>	Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any payment to induce or reward referrals of items or services paid in whole or in part under a federal health care program.
<b>18 USC 1347 Criminal Health Care Fraud Statute</b>	Prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice: <ul style="list-style-type: none"><li>• To defraud any health care benefit program;</li><li>• To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program;</li></ul> Proof of actual knowledge or specific intent to violate the law is not required.



## Criminal Penalties Can Include

Fine of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment

# Oregon False Claims Statutes

<b>ORS 411.670 to 411.690</b>	<b>Oregon Medicaid Program Statutes:</b> Submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery
<b>ORS 646.505 to 646.656</b>	Unlawful trade practices
<b>ORS chapter 162</b>	Crimes related to perjury, false swearing and unsworn falsification
<b>ORS chapter 164</b>	Crimes related to theft
<b>ORS chapter 165</b>	Crimes involving fraud or deception, including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments)
<b>ORS 166.715 to 166.735</b>	Racketeering – civil or criminal
<b>ORS 180.755 to 180.760</b>	Oregon’s False Claims Act
<b>ORS 659A.200 to 659A.224</b>	Whistleblowing
<b>ORS 659A.230 to 659A.233</b>	Whistleblowing
<b>OAR 410-120-1395 to 410-120-1510</b>	Program integrity, sanctions, fraud and abuse; common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.

# Exclusions

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The Office of Inspector General (OIG) in the Department of Health and Human Services is required to impose exclusions from participation in all Federal health care programs for providers who have been convicted of:

- Medicaid or Medicare fraud;
- Patient abuse or neglect;
- Felony convictions for other health care related fraud, theft, or other financial misconduct;
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

42 U.S.C. Section 1320a-7

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901



# Behavioral Health Risk Areas:

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*During the last few years, the Office of Inspector General, through settlement of civil False Claims Act cases, and the prosecution of criminal activity, has compiled a list of areas that are typically vulnerable to fraud or other misconduct.*

*Most frequent behavioral health audit findings include:*

- Poor documentation including non-existent documentation, documentation that did not support medical necessity, lack of annual updates, and documentation errors
- QMHA provided services outside the scope of practice
- Billing for services not provided/units that exceed time spent
- Billing for services over the phone that are not covered
- Duplication of billing within the mental health staff

# 2013 New Mexico Behavioral Health Provider Audits

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- In February 2013, the New Mexico Human Services Department contracted with a consulting agency to audit 15 New Mexico mental health and substance abuse providers were audited. These providers constituted approximately 87% of Medicaid and non-Medicaid behavioral health services in 2012.
- *Clinical Findings: Identified more than \$36 million in overpayments to these 15 providers over a three-year period from 2009-2012.* This amounted to nearly 15% of all payments made to these providers (typically overpayments are expected to be 3% - 9%).



# Common Issues Across New Mexico Providers included:

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- **Assessments (psychosocial/psychiatric evaluations) were not up to date** (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
- **Treatment plans were not up-to-date and individualized.** Updated treatment plans are necessary to determine any changes to goals and objectives, in addition to progress or lack of progress by the consumer. Without updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.

# New Mexico Clinical Documentation Issues (cont'd)

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- Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
- Interventions in the progress notes did not always link to the consumer's treatment plan or support the program definition of the billed service.
- Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
- Billed units did not match the units documented on the progress notes.
- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations, homicidal ideations, self harm or domestic violence.

# How Do We Stay On Track?

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# MHASD Compliance Program

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MHASD's Compliance Program is a systematic process aimed at ensuring that our work is conducted in compliance with applicable laws, standards, and contractual obligations.

MHASD's compliance program includes

- employee and subcontractor training
- internal and external provider agency monitoring
- regular coordination with the Department and Multnomah County structure
- accessing training opportunities and information on new developments in behavioral health compliance.

# Compliance Plan Elements

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## Seven Elements of a Compliance Program



- 1) Designate a compliance officer
- 2) Develop written standards and policies to implement the compliance program and govern operations
- 3) ***Implement training and education programs***
- 4) Establish effective, clear, open lines of communication
- 5) Conduct internal monitoring and regular audits
- 6) Respond to detected issues
- 7) Publicize and enforce disciplinary standards

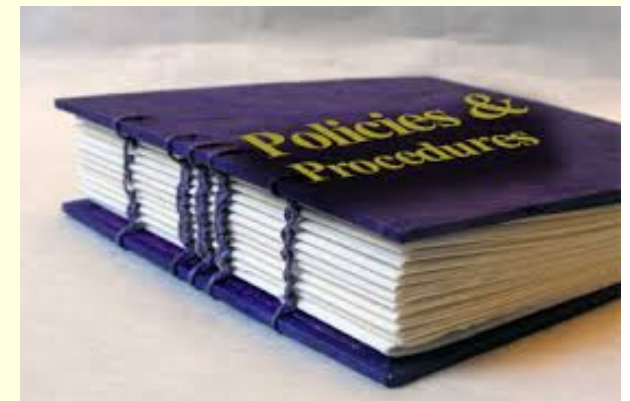
# Policies, Procedures & Standards

## Core Compliance Policies

- MMHBA-020: Fraud and Abuse Monitoring Procedures
- MMHBA-021: Division/Contracted Provider Education and Training for the Prevention & Identification of Fraud and Abuse
- MHASD195: Non-Retaliation, Employee Whistle Blower Protections
- MMHBA-023: Division Medicaid Compliance Plan
- MMHBA-005: Third Party Liability Recovery
- MMHBA-010: Overpayment Procedure
- MMHBA-025: Encounter Data Verification
- MMHBA-060: Oversight for Recovery of Third Party Resources and Personal Injury Liens
- CER-001: Certificate of Approval Initial Application
- CER-002: Certificate of Approval Renewal
- MHAD100: Consumer Complaint and Grievance Process
- MHAD141: Internal Staff Credentialing

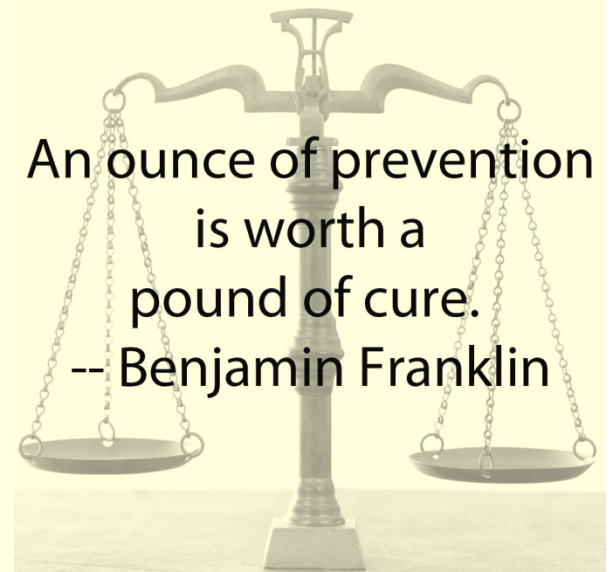
## Personnel Rules

- Employee Responsibilities: Rule 3-10
- Code of Ethics: Rule 3-30
- Use of Information Technology: Rule 3-35
- Maintaining a Professional and Respectful Workplace: Rule 3-47
- Discipline and Dismissal: Rule 3-60
- Recruitment and Examination: Rule 5-20
- Records Management: Rule 5-65



# Preventing Fraud & Abuse

- **Hiring Procedures**
  - Credentialing, including checking federal exclusion lists
  - Conflict of Interest forms
  
- **Clinical/Business Staff Training**
  - Documentation Training
  - Level of Care Utilization
  - Separation of Duties for both Clinical Care and Business Services
  - Supervision
  
- **Internal Monitoring:**  
**MMHBA 020 Fraud & Abuse Monitoring**
  - Prospective auditing
  - Regular exclusion list checks
  - Involvement with HR, Business Operations, Quality Management etc.



# Detecting Fraud & Abuse

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## What are my responsibilities?

- Make sure you are up to date with laws, regulations, MHASD policies, Multnomah County Personnel Rules, and trainings. If you have questions, please talk to your manager/supervisor.
- **Work Rule (Duty to Report):** MHASD employees have the responsibility to report to the division Compliance Officer, in good faith, any concerns regarding actual, potential or perceived wrongdoing or violations of the False Claims Act, or other county personnel rules that outline ethics and employee code of conduct. Compliance Officer: Nicole Cleary (503) 988-3026
- MHASD staff can also report directly to the Good Government Hotline or applicable oversight entity (Regional Medicaid Fraud Control Unit) any actual, potential, or perceived wrongdoing as stated in the work rule above.
- MHADM 195 Non-Retaliation, Employee Whistleblower Protection establishes that retaliation for good faith reporting is strictly prohibited.



# Reporting Fraud & Abuse



## Good Government Hotline:

Reporters can access the Multnomah County Auditor's Good Government Hotline in a variety of ways:

- Proceed directly to the Multnomah County EthicsPoint reporting page at [www.GoodGovHotline.com](http://www.GoodGovHotline.com) to submit an online report.
- Access EthicsPoint at [www.ethicspoint.com](http://www.ethicspoint.com). Follow the "File New Report" link and enter "Multnomah County."
- Call EthicsPoint at 888-289-6839 (toll free) 24 hours a day, 7 days a week. Reports will be taken by a live intake specialist. Calls are not recorded and caller ID is disabled.

- **Medicaid Fraud Control Unit of Oregon**  
Office of the Attorney General  
1515 SW 5th Avenue, Suite 410  
Portland, OR 97201  
(971) 673-1880  
(971) 673-1890 fax
- **Oregon DHS Fraud Investigation Unit**  
P.O. Box 14150  
Salem, OR 97309-5027  
Office of Payment Accuracy & Recovery  
Fraud Hotline:  
1-888-FRAUD01 (372-8301)  
or [report fraud online](#)

# Checking Understanding

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- What are some examples of Fraud and Abuse?
- What did you learn today about the laws pertaining to fraud and abuse?
- How does MHASD work to prevent fraud and abuse in our operations?
- How do you report suspected fraud or abuse?

