FRAUD PREVENTION IN MEDICAID

Dr. SERPIL TOKDEMIR YUCE, Ph.D.
Office of Medicaid Inspector General
Arkansas State – USA
About 5% of home healthcare agencies show potential signs of fraud

By Lisa Schencker  |  June 23, 2016

More than 500 home healthcare agencies—about 5% of the total—and 4,500 doctors across the country share characteristics that often point to home healthcare fraud, according to a report released by HHS’ Office of Inspector General on Wednesday.

An alert (PDF) that accompanied the report (PDF) warned that the federal government is stepping up enforcement when it comes to such crimes.

According to the Office for Inspector General, home healthcare fraud cases typically involve five characteristics, including high percentages of:

• episodes of care during which a beneficiary had no recent visits with the supervising doctors
• episodes of care not preceded by a hospital or nursing home stay
• episodes of care with a primary diagnosis of diabetes or hypertension
• beneficiaries with claims from multiple agencies
• beneficiaries with multiple home health readmission in a short time
Feds recommend Alabama pay back nearly $100 million in improperly claimed Medicaid money
Mission of OMIG

• To detect and prevent **fraud, waste, and abuse** within the medical assistance program

• Verify whether services reimbursed by Medicaid were properly billed and actually furnished to beneficiaries;

• Recover improperly expended funds
OMIG Auditing with Data Analytics

Top outliers are selected for audit or investigation

- Audit and Fraud Detection System
  - Review and analysis of payments and billing claims
  - Report Studio / Query Studio - OPTUM
## Arkansas Title XIX

### Provider Detail Report

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### Overall - Summary

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### Note

- The table above provides a sample of the data that might be included in a Provider Detail Report for Arkansas Title XIX.
- The specific columns and data types listed are illustrative and may vary depending on the actual data structure used.
- The sample data showcases typical fields such as billing provider details, recipient details, and service dates.
- The report is designed to aggregate and display summarized information from different data points, facilitating analysis and reporting on provider and recipient data.
OMIG Auditing with Data Analytics

- Provider Spike Detection: Increase/Decrease
  - Spike Detection compares a provider to his own previous activity, and not against his peers
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OMIG Auditing with Data Analytics

• Peer Review Analysis and Outlier Identification
  • Top outliers are selected for audit or investigation – when billing stands out from the average in peer group
FADS: PEER GROUP PROFILING

• Peer Group Profiling study can be constructed to
  • identify peers – providers who are similar on user-defined criteria – and
  • rank those peers in order of severity based on a statistically proven method
• Peer Grouping is a tool to compare overall behaviors among a population with common characteristics.
FADS: PEER GROUP PROFILING

Defining a Study

Once you have a study idea, you will need to define the study. Answer these basic questions:

1) Who? Who do you want to study?
   a) Do you want to study providers or beneficiaries?
   b) Are there specific criteria which would further define these providers or beneficiaries?

2) What? What do you want to count, sum, or divide (for comparison)?
   a) What criteria do you want to count?
   b) What criteria do you want to sum?
   c) What criteria do you want to divide (for comparison)?

The first step to build effective studies in Peer Grouping is to understand the statistical method which it uses.

In a study designed to review office visits, all providers in the Study Group with claims paid for office visits are counted.

1. For each provider, the percentage of high-level visits over all office visits is calculated.
2. The average of this percentage across the entire study group is determined.
3. The standard deviation is calculated using the common statistical formula to measure the variation of the percentage within the group. The lower the number, the greater conformity within practice patterns. The higher the number, the more variation observed within the practice patterns.
4. The upper limit is calculated, using 2.0 standard deviations (as a default). That is, the group’s average, plus the value of two standard deviations equal the upper limit of acceptability.
5. Any provider whose percentage of ‘high-level office visits to all office visits’ is above the upper limit is ranked as a suspect.

Average percentage for all providers within this study group: 11
Value of one standard deviation: 16
Upper limit: \[ 11 + 16 + 18 = 43 \]

So, the exception processing logic within Peer Grouping would report all providers with a percentage over 43 on the Ranking Report.
FADS: PEER GROUP PROFILING
FADS: PEER GROUP PROFILING

![Study Library browser page](image-url)
OMIG Auditing with Data Analytics

• Algorithms: These studies are customized to your detailed specifications, based on your policies and procedures.
### FADS: FRAUD ALGORITHMS

[Image of a table or chart related to fraud algorithms]

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OMIG Auditing with Data Analytics

- OMIG Data team studies
  - Gephi
  - Excel - PowerQuery
DATA TOOLS

• GEPHI:
  • This is a software for *Exploratory Data Analysis – open source and free!*
  • Make hypothesis
  • Intuitively discover patterns, and
  • Isolate structure singularities or faults during data sourcing
  • Metrics:
    • The statistics and metrics framework offer the most common metrics for social network analysis (SNA) and scale-free networks. Betweenness Centrality, Closeness, Diameter, Clustering Coefficient, PageRank
    • Community detection (Modularity)
  • Geographic map with Geolayout feature
• Opioid Users – Network of doctor shoppers
  • Beneficiaries with at least:
    • 4 Opioid drug claims
    • 4 different prescriber
    • 4 different billing provider – Pharmacy
    • Additionally, we have calculated the MME (Morphine Milligram Equivalent) factor per daily taken opioid dosage

To Fraud, or Not to Fraud . . .

• Personal Care agency audited for 1 month of billing. (59 recipients)
  • No documentation to support medical necessity (all 59 recipients)
  • Unable to validate qualifications for performing providers (44/59 recipients)
  • Service plans for 14 recipients did not have physician signature
  • Units billed exceeded units documented (44 rec.)
To Fraud, or Not to Fraud . . .

Reconsideration Request

This is a request for reconsideration from [redacted] for the finding noted in our audit. [Redacted] is a new business that began operations in Arkansas in 2013. The owners were not only a new business but also new to the reporting requirements required by Medicaid. There were findings and observations brought to our attention that we were not aware of and also did not know that these finds/observation were required by Medicaid. Also during our audit, it was brought to our attention that there was a Personal Care Manual and also a Medicaid Manual. We are new to the business and still learning but once we were notified that we needed to make changes, the changes were made. This will ensure the business is executed properly. We except any discipline that OMIG deems fair for the finds/observations that we were out of compliance. We ask a second chance to provide the necessary documentation to support the services we are providing to the community. We have one goal and one goal only, and that is to assist people that need assistance with daily living. We have put in place procedure to assist us with making sure we are in compliance with Medicaid. Now that these issues have been brought to our attention, we will follow that guidelines created by Medicaid.
NOT FRAUD (but really close)

• $40,732.71 Recoupment /Corrective Action Plan requiring training and follow up audits
To Fraud, or Not to Fraud . . .

Analytic Review of Counseling Services

1) LPC - $706,523.73
2) PC - $571,850.54
3) 3rd highest reimbursed D LPC Provider - $145,315.88
To Fraud, or Not to Fraud . . .

Analytics Review of Top Therapy Billers

- *Data trend shows pattern of excessive billing with fewer recipients being identified*

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To Fraud, or Not to Fraud . . .

OMIG staff reviews documentation for billing

• Submitted documents did not justify the services of the amount of Medicaid payments

  Appeared like Provider billed twice for every service

• OMIG staff requested an explanation from the provider for the overbilling

AND . . . .
It reflects my guilt of double billing.

Sent from my iPhone

On May 28, 2015, at 2:30 PM, "David Jones (DHS OMIG)" <David.Jones.OMIG@dhs.arkansas.gov> wrote:

Hello,

I have reviewed most of the progress notes, but I have a question regarding the billing. As per our first conversation, it appears that most services are billed for 16 units; however, 16 units are not documented in the medical record. Can you please explain your billing process, and how you determine the 16 units?

Thank you

David

David Jones, LCSW
Office of Medicaid Inspector General
323 Center Street Suite 1200
Little Rock, AR 72201
501-537-1679
david.jones.dms@dhs.arkansas.gov  

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New email address
FRAUD

20 Years Prison sentence (suspended)
$200,000.00 in Restitution
To Fraud, or Not to Fraud . . .

Analytics reveal suspicious/unusual billing involving CPTs 99211 and 90882

- **CPT 99211** - an office or other outpatient visit “that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.”

- **CPT 90882** - Environmental Intervention – activities covered include physician visits to a work site to improve work conditions . . . on behalf of a chronically mentally ill patient to discuss a change in living conditions, . . .
To Fraud, or Not to Fraud . . .

Finding 1 – Improper Billing of CPT Code 99211
Review of the beneficiaries’ medical records revealed six hundred forty one (641) instances for one hundred seventy six (176) beneficiaries where no current primary care physician referral was documented for services billed.

Finding 2 – Improper Billing of CPT Code 90882
Review of the beneficiaries’ medical records revealed eight hundred eleven (811) instances for one hundred eighty eight (188) beneficiaries where no current prescription was documented for services billed.

Finding 3 – No Documentation for Services Billed
Review of the beneficiaries’ medical records revealed six (6) instances for five (5) beneficiaries where there was no documentation for services billed. Documentation submitted by provider stated the missing documentation was due to billing date errors.

Finding 4 – Progress Note Documented a Non-Billable Service
Review of the beneficiaries’ medical records revealed one hundred forty-eight (148) instances for fifty-nine (59) beneficiaries where progress notes documented a non-billable service. Documentation included, but not limited to, faxing prescriptions to pharmacies, faxing paper work for Prior Authorizations, and reminding beneficiaries of appointments.
To Fraud, or Not to Fraud . . .

Response to Audit by Provider Attorney

Dear Mr. Dickinson:

With respect to the above-referenced matter, please find attached the various spread sheets in connection with the billing of 99211 and 90882. Also attached, please find the affidavit of [redacted] who as you know does the Medicaid billing.

The prior billing of 99211 was billed in connection with the various case numbers because [redacted] and his billing assistant were simply not aware of the appropriate codes or the fact that the code billed was not appropriate at the time of the billing. Likewise, for the prior bills for 90882.
NOT FRAUD

• $35,000.00 Recoupment and Corrective Action Plan
To Fraud, or Not to Fraud . . .

*Speech Therapy* Review

- Data Analysis reveals excessive therapy hours for Speech therapist and STA
- Desk review turns into Field Audit based on concerns of billing
- School based therapy not being reported and school districts not paying required state matching funds
To Fraud, or Not to Fraud . . .

Lack of Progress Notes
- Provider uses “tally sheets” instead of progress notes
- Provider could not produce “tally sheets”
- Progress notes miraculously appear one hour after interview
- Progress notes provided contradict the medical records
  
  Therapist and Therapy Assistant admit to creating records for desk audit

Group Therapy sessions:
- Therapists and STA perform sessions at same time in same small room
- Group Therapy documentation notes do not list the same activities for group members
  
  Individual therapy sessions billed for Group Therapy Sessions

LEA billing:
- Therapist had never listed an LEA number for 8 years of school-based therapy services

Billing hours include 5:30 a.m. and 7:30 p.m.
  
  STA admits they bill for Therapy when “helping with homework”
FRAUD

• Therapists is facing Felony Medicaid Fraud Charges
• Therapy Assistant – plead guilty and fined $17k and Restitution $5k
5 Year Analysis of Medicaid Recoupments and Claims

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>$1.1 million</td>
</tr>
<tr>
<td>FY 2014</td>
<td>$2.1 million</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$3 million</td>
</tr>
<tr>
<td>FY 2016</td>
<td>$2.7 million</td>
</tr>
<tr>
<td>FY 2017 (proj)</td>
<td>$3.3 million</td>
</tr>
</tbody>
</table>
SFY 2017 Initiatives

Behavioral Health Reform (Group Psychotherapy)
Transportation
Vision, Dental & Pharmacy
In-patient Hospital Stays
School-Based Therapy
Dual Eligible Recipients Payments
Personal Care and Home Health Reform
Medicaid Enrollment (Arkansas Works FFM)

*Total Cost Savings Impact of more than $30 million*
SFY 2018 Initiatives

Opioid Initiative
Behavioral Health – (MHPP review)
Personal Care & Home Health rendering provider ID
Dental Managed Care Preparation
Provider Led Organization and Managed Care Models
MMIS Edit process
Medicaid Provider and Recipient Enrollment
Thank You!

Questions?