Welcome to the Washington, DC Medicaid Academy

Meet Our Training Team

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Your Agency's Team Includes:

Executive Lead

Program Lead

Fiscal Lead

Quality Lead

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How is everyone doing today?

Purpose of Medicaid Academy Learning Sessions

DHCF and DHS provides the WHAT/ Policy requirements

The TA Team helps with HOW so you can develop a plan for your agency

Each session will include:

Helpful tips and tools provided by the TA team

Opportunities for sharing experiences across agencies

Coaching for your agency

[DHS on PSH]

[The approved State Plan Amendment]

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Plan for Today: Session 5

- ✓ Review key elements of Medicaid Compliant Documentation and look at documentation examples
- ✓ Learn about how DHCF will communicate with you regarding submitted claims
- ✓ Review the process for billing and payment
- ✓ Identify themes and areas needing improvement and create next steps for your work plan to maximize billing revenue

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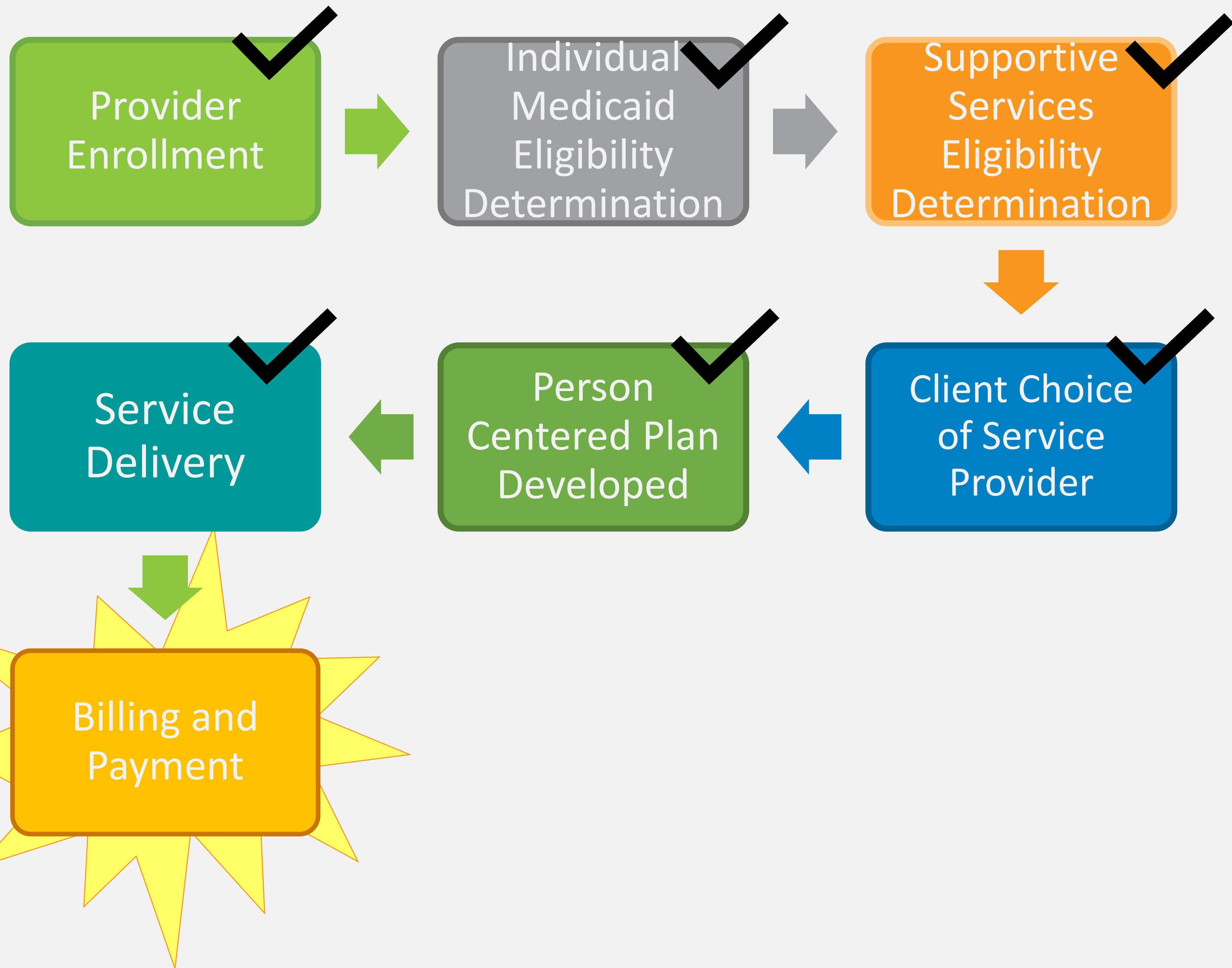
Medicaid Housing Supportive Services Process



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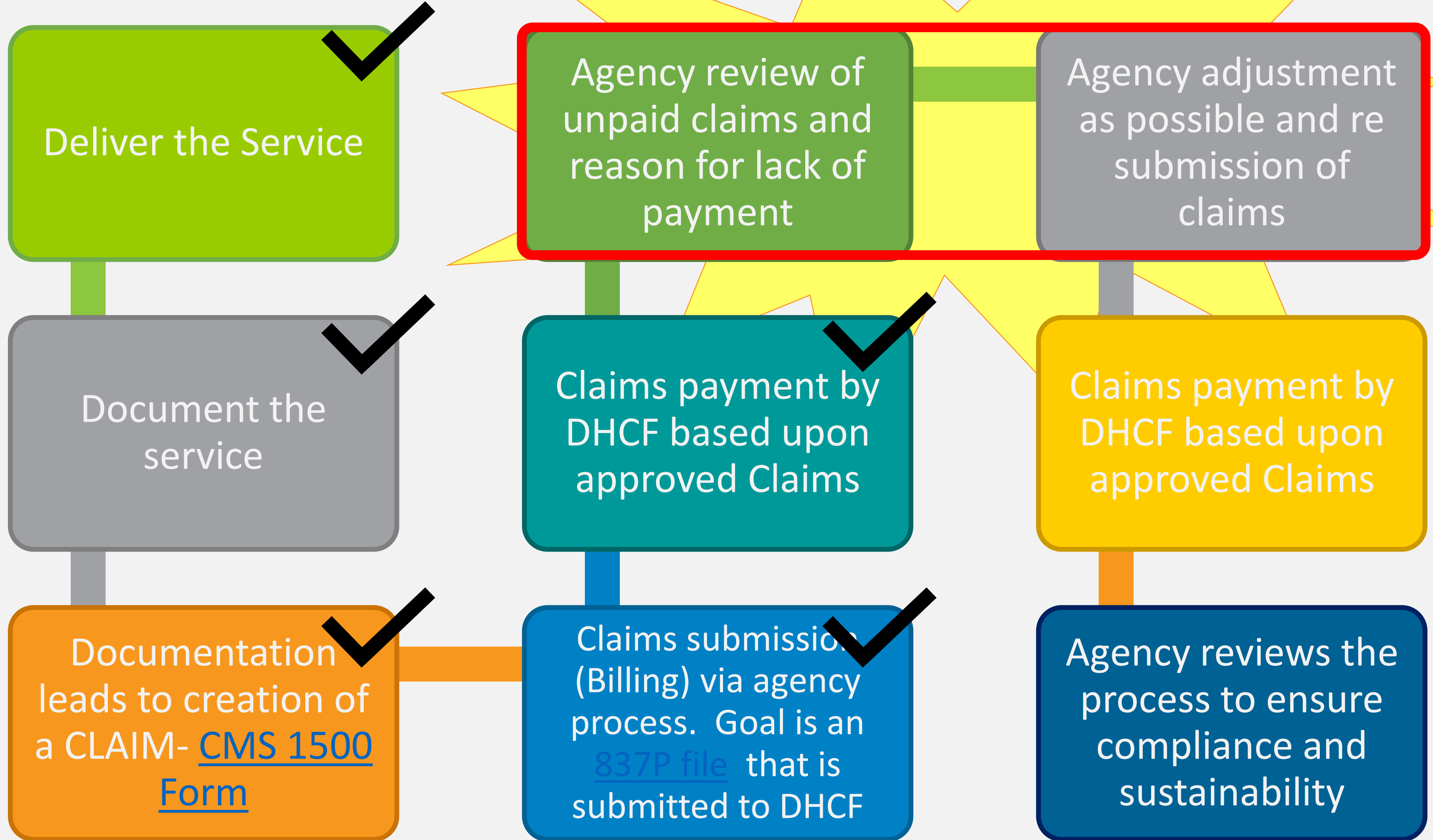
Billing & Payment Process



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Internal Monitoring and Audits

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Preventing Fraud, Waste & Abuse – Provider Role

Conduct Regular Self-Audits

- Assists providers with prevention
- Identifies submission of erroneous claims
- Helps to prevent engaging in unlawful conduct involving the health care programs
- Aids in identifying inefficient business practices

https://dhcf.dc.gov/page/provider-self-audit

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Preventing Fraud, Waste & Abuse – Provider Role

Self-Audit Worksheet Explanation

A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. The worksheet is an example of a format that could be used to submit a self-audit to the Agency. It is not the required format but is designed to ensure that you furnish the Agency with all of the information that is necessary to validate and accept your self-disclosure. The chart below is an explanation of the items requested on the worksheet.

If a provider determines that payments made to it were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the District of Columbia. In fact, the provider can be sanctioned for failure to do so.

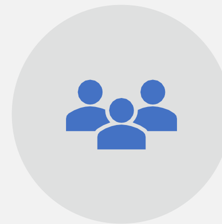
PROVIDER NAME – the name of the provider who received payment from DHCF	**DATE** – the date the worksheet was prepared
MEDICAID PROVIDER NUMBER – the nine (9) digit provider number to which DHCF made payment	**CONTACT PERSON** – name of the person to contact about the self-audit
PROVIDER TYPE – enter the type of provider you are enrolled as (for this provider number)	**TELEPHONE NUMBER** – telephone number for contact person
TAX I.D. – the federal tax identification number for the provider conducting the self-audit	**PROVIDER ADDRESS** – the address for written correspondence regarding the self-audit
NPI NUMBER – the national provider identifier for the provider conducting the self-audit	**AUDIT PERIOD** – the time period covered by the audit (start date to end date)
AUDIT TYPE – a comprehensive audit is a review of all claims (or a sample of all claims for a given time period); a focus review is an audit of a subset of the provider's claims, such as specified services	
STATISTICS USED – indicate whether the audit involved the use of statistical sampling for purposes of reviewing claims	**SAMPLE FROM DHCF** – if statistical sampling was used, indicate whether DHCF assisted with obtaining the sample
AUDIT METHODOLOGY – provide a written explanation about how the audit was conducted; be as detailed as possible	
AUDIT FINDINGS -- identify the claims that were reviewed and the findings of the review (whether the claim should be allowed or denied, and reasons for the denial)* see examples below • Service not rendered • Up-coding • Unqualified staff performing services • Incorrect dates of service • Incorrect recipient • Duplicate services • Unbundling • Service not documented	• Not covered • Not medically necessary • Accompanied by inappropriate (or absent) modifier(s) • Double-billed • Misrepresented (incorrect location, date, time, sequence, frequency, quantity, description, staff, licensure, etc.) • Under(over)utilized • Billed as a consultation rather than an office visit

Internal Chart Reviews & Audits Process

Timing

Frequency

Number of records for each type of review



Designated Staff

Correcting Mistakes

Reports

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Internal Monitoring and Audits

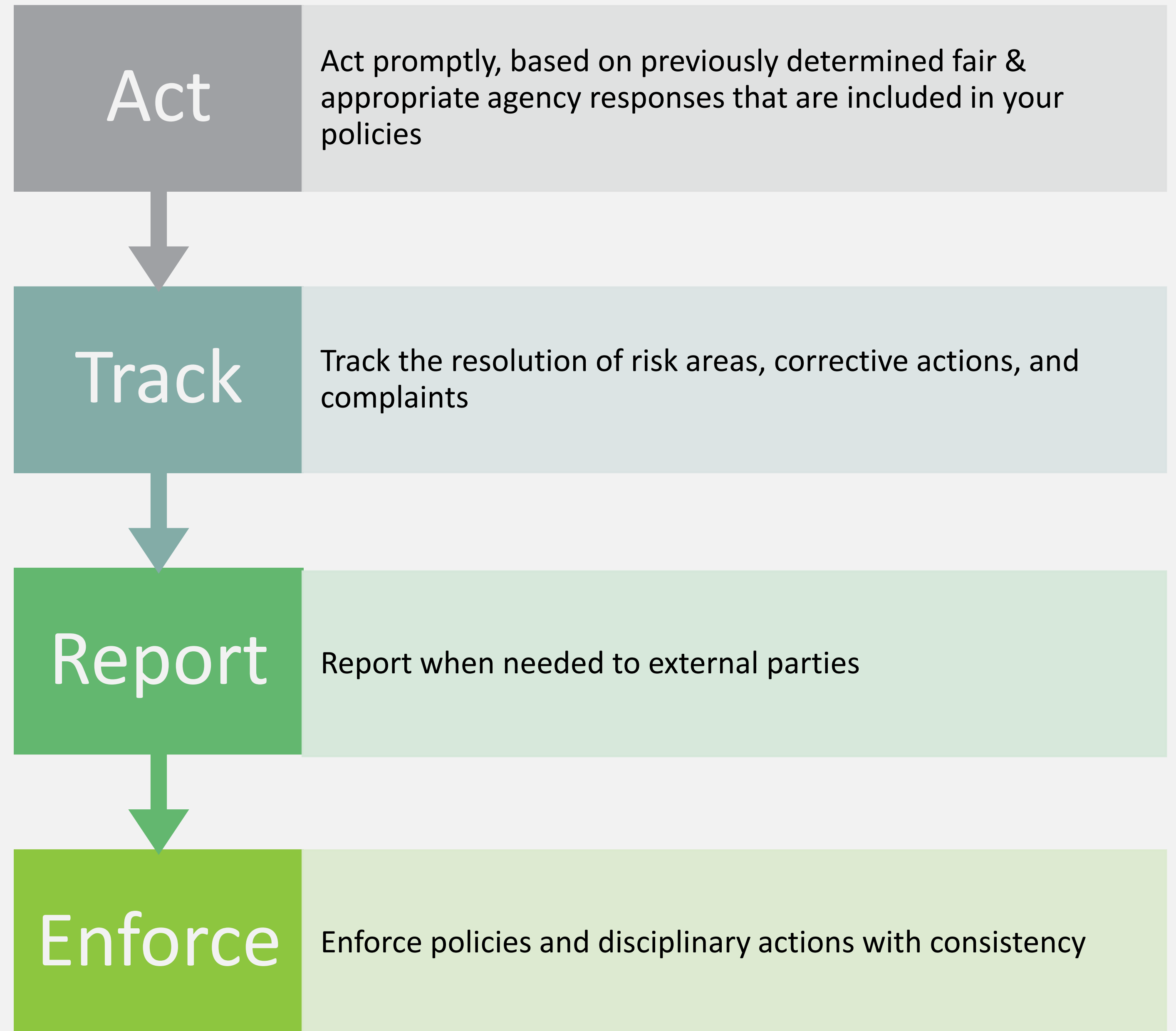
CONDUCT REVIEWS OF AGENCY BILLING CODING, CHARTS AND QUALITY OF CARE

HAVE A PLAN FOR HOW INTERNAL AUDITS ARE CONDUCTED

IDENTIFY AREAS AT RISK FOR EXTERNAL AUDITS

Corrective Action Planning and Enforcement:

Begins with Identification



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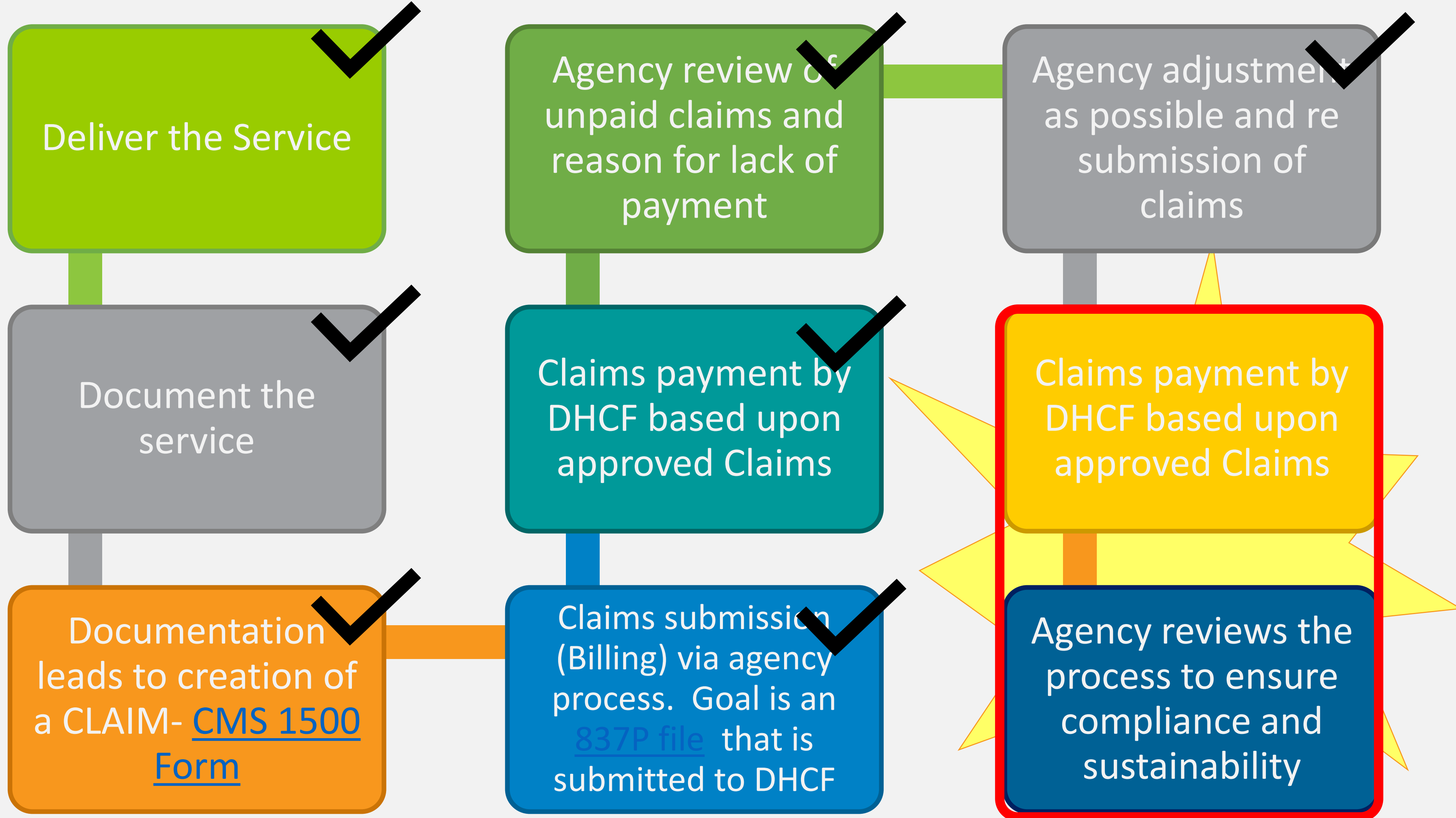
Billing & Payment Process



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External Monitoring and Audits

Provider Audits

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Division of Program Integrity Surveillance Utilization Review Section (SURS)

- The primary mission of The Division of Program Integrity (DPI) is to identify, prevent, and recover improper payments.

- The Office of Program Integrity maintains a strong commitment to identify improper payments, and potential fraud, waste and abuse to ensure that State and federal tax dollars are spent appropriately. This commitment is driven by a firm intent to assure that the right provider is receiving the right payment for the right services at the right time.

- We strive for collaboration and partnership with internal and external stakeholders to improve accountability for how health care funds are spent. Coordination of Medicaid fraud, waste and abuse activities requires partnership with every administration entrusted with taxpayer dollars. Program Integrity is everybody's business

Regulations that Authorize Medicaid Surveillance and Recoupment Activities

- Federal and State laws mandate identifying and recovering improper payments and other program integrity activities through audits, investigations and reviews.
- Federal Executive Order No. 13520 (11/20/09)
- Improper Payments Information Act of 2002
- Presidential Memorandum Regarding Finding and Recapturing Improper Payments (3/10/2010)
- Other Federal mandates and requirements: Code of Federal Regulations
  - 42 CFR 431.10 State agency designee to administer Medicaid Program
  - 42 CFR 447.202 Payment for services - Audits
  - 42 CFR 455 Program Integrity: Medicaid
  - 42 CFR 438 Managed Care
  - 42 CFR 456 Utilization Control
  - 42 CFR 1001 Program Integrity
- Title: 29 Public Welfare - Chapter: 29-13 Medicaid Program Administrative Procedures
- Sec. 1902. [42 U.S.C. 1396a] - STATE PLANS FOR MEDICAL ASSISTANCE

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Division of Program Integrity Webpages

Use either link to Navigate to PI webpages

Use link to Report Fraud and abuse

dhcf | Department of Hea

dhcf.dc.gov

311 Online Agency Directory Online Services Accessibility

DC.gov

Mayor Muriel Bowser

Search DC.gov

DC.gov dhcf.dc.gov

Department of Health Care Finance

Home | Services | Medical Assistance Information | Providers | Policies | Health Information Exchange | Ombudsman | About

Important Notice for Primary Care Providers

Conflict-Free Case Management

Division of Program Integrity (DPI)

Long Term Care Providers

Medicaid Program Integrity

Person-Centered Planning

Provider Information and Forms

Telemedicine

Medicaid Program Integrity

To Report Medicaid Waste, Fraud or Abuse call 1-877-632-2873.

DC State Innovation Model (SIM)

Over the course of the year, a diverse group of stakeholders have come together develop a State Health Innovation Plan (SHIP) for DC. We are pleased to announce our recently released interim SHIP and would like to hear from you!

About DHCF

The straightforward mission of the agency is to improve the health outcomes of low-income residents of the District by providing access to a full range of preventative, primary, urgent and critical health care services.

Prev Next

Featured Services

Report Medicaid Fraud and Abuse
Click here to report fraud and abuse.

How to Apply for Medical Coverage
Information and eligibility for applying to the MAGI Medicaid program.

Health Care Alliance
This program serves residents with no other insurance and not eligible for Medicaid or Medicare.

Qualified Medicaid Beneficiary
This program helps District residents

DC Healthy Families
DC Healthy Families program covers

Apply for Medicaid
Medicaid helps pay for medical

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Fraud, Waste & Abuse…

FRAUD - An 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

- Billing for services or supplies that were not furnished or provided
- Altering claim forms and/or manipulating records in order to receive higher payment amounts
- Falsely representing the nature of the services furnished
- Soliciting recipients for equipment not needed
- Completing certificates of medical necessity for patients not professionally known by the provider

Code of Federal Regulations, Title 42, Part 455

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Fraud, Waste & Abuse…

WASTE - Incurring unnecessary costs as a result of deficient management, practices, or controls.

- Includes practices that, directly or indirectly, result in unnecessary costs to the Medicaid Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

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Fraud, Waste & Abuse…

ABUSE - Provider practices that are inconsistent with sound fiscal, business, or medical practices.

- Includes provider or recipient practices that result in unnecessary cost to the Medicaid program
  - Charging in excess for services
  - Submitting bills to Medicaid/Medicare that are the responsibility of other payers
  - Reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare

Code of Federal Regulations, Title 42, Part 455

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Fraud, Waste & Abuse – False Claims Act

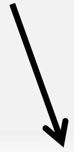
The Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.

- Knowingly presenting, or causing to be presented a false claim for payment or approval

- Requires an overpayment 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 any corresponding cost report is due, if applicable.

The "5 Rights"

The right care

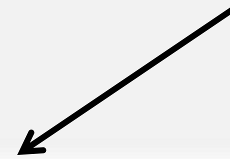


In the right amount

At the right time

For the right patient

In the right setting



The "6th Right"

The Right Payment

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Audit Types

- Desk Audit-Review
- Onsite / Field Audit

Desk Audits and Reviews

- A **Desk Audit** is an audit or review conducted at the Division of Program Integrity.

- A notification letter with request for records may be sent to the provider and generally requires the provider to submit copies of the requested records.
  - Audit staff may conduct provider and/or provider personnel interviews by phone.
  - Some examples of desk audits and reviews are clinical reviews, pharmacy third party liability (TPL) audits, hospital outpatient claims audits, and hospital credit balance reviews.

- **Data mining/Algorithm Based Desk Audits and Reviews** are conducted by applying rules-based filters (called algorithms) to claims payment data to identify overpayments within the District of Columbia Medicaid program.

Onsite/Field Audit

- The SURS team conducts an entrance conference with the providers designated personnel to:
  - Introduce each team member
  - Explain the nature and purpose of the utilization review
  - Request selected recipient medical records for the utilization review
  - Request all records, and items needed for the survey
  - Conduct the utilization review by following the survey tool which includes touring the facility to ascertain appropriateness of equipment and suitability of area for patient care and services
  - Conduct an exit conference to present tentative finding to provider
  - Have the provider representative sign the exit conference summation sheet indicating that they have had the opportunity the meet with the SURS team and was given an explanation of the tentative findings.

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The Audit Process

- Select a Topic
- Identify Measures
- Identify Patient Population
- Determine Sample Size
- Create Audit Tools
- Collect and Analyze the Data
- Summarize Results
- Apply the Results

Corrective Actions

- Provider Education
- Regular Monitoring
- Designation as a “High Risk Provider”
- Mandated Compliance Training

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Compliance Training Programs

Compliance programs components:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines

https://dhcf.dc.gov/page/provider-compliance-programs

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Potential Consequences

- Recoupment of Payments
- Monetary Penalties
- Potential Referral to Investigation which could result in:
  - Program Exclusion
  - Possible Criminal Prosecution
  - Provider Suspension

Breakout Room Questions

Add to your

Agency's Work Plan

based on what you have learned so far

15 minutes for teams to consider

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Language Access Program

- The Language Access Act of 2004 was enacted by Mayor Anthony A. Williams on April 21, 2004. The Act's purpose is to provide greater access and participation in public services, programs and activities for residents of the District of Columbia with limited or non-English proficiency (LEP/NEP).

- The Department of Health Care Finance is a Covered Entity with Major Public Contact under the Language Access Act.

- All Medicaid Providers are considered Contractors

- All providers serving Medicaid beneficiaries are responsible for ensuring translations and interpreter services are available for patients who need them.

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Language Access Program

Language Access Program - Definitions

LEP

A "LEP" or "Limited English Proficient" individual refers to an individual who **does not** *speak English as his/her* **primary language** and *has a* **limited ability** to speak, read, write or understand English.

NEP

A "NEP" or "Non-English Proficient" individual refers to an individual who **cannot** *speak or understand the English language* **at any level**.

Language Access Program - Provider Role

- To request an interpreter service through DHCF, please fax the completed request form to
  - 202-722-5685

- Questions regarding the Language Access Program should be directed to:
  - Dr. Antonio Lacey, Program Analyst
  - Email: antonio.lacey@dc.gov
  - Phone: 202-442-5847

- Beneficiaries Concerns should be directed to:
  - Ombudsman Office at 202-724-4788

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Medicaid Integrity Program- Educational Resources

- CMS has resources that cover important topics in Medicaid program integrity. They are organized by audience and by topic to help you easily find what is most relevant to you.
- A list of all current resources is available in the Resource Library, where you can sort and filter by topic, date, and keyword.
- Medicaid Program Integrity Educational Resources | CMS

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DC Medicaid Academy Schedule

Up Next

Q&A on today's session
Thursday, August 25th 12 PM about what we learned today.

Session 6: Quality Standards
Tuesday, August 30, 2022
3 PM -5PM EST

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Planning ahead for Session 6

Who needs to attend:
Executive Director, Program Lead and QI

What do you need to gather and have access to during Session 6:

- ❑ Have your team workplan out and ready
- ❑ Have access to current policy manual and Quality Improvement Section
- ❑ Progress case notes from 2-Clients
- ❑ Client File

THANK YOU

Please join us again for one of our many course offerings.
Visit **www.csh.or/training**