Office of Program Integrity Overview

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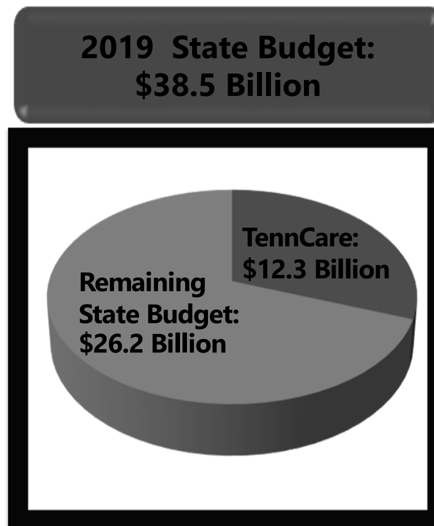
1

Managed Care in TN

- TennCare
  - 100% Managed Care
  - Funded:
    - ✓65% Federal
    - ✓35% State
  - Serve 1.5M members
  - Providers 65,000+

2019 State Budget: $38.5 Billion



2

2

Program Integrity Purpose

- Mission
  - Monitor the integrity of TennCare' s provider claims and MCO activity to ensure that they are reasonable, appropriate, and comply with TennCare Rules and Policies.
- Goal
  - Develop a reasonable and consistent system of oversight which effectively encourages compliance, maintains accountability, protects public funds, and supports awareness and responsibility.

See 42 C.F.R. § 455.12 et seq.

3

Program Integrity Functions

- Prevention and Detection
- Desk and Field Audits
- Data Mining Projects
- Cost Savings Proposals
- Educate and Improve Awareness
- MFCD/Law Enforcement Collaboration
- Recoupment of Overpayments
- Appeals-ALJ Hearings
- MCO Oversight

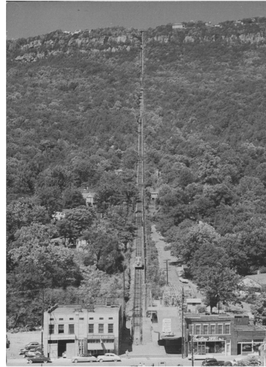
4

OPI Compliance Role

- The OPI Compliance unit monitors all of the MCO's program integrity functions.

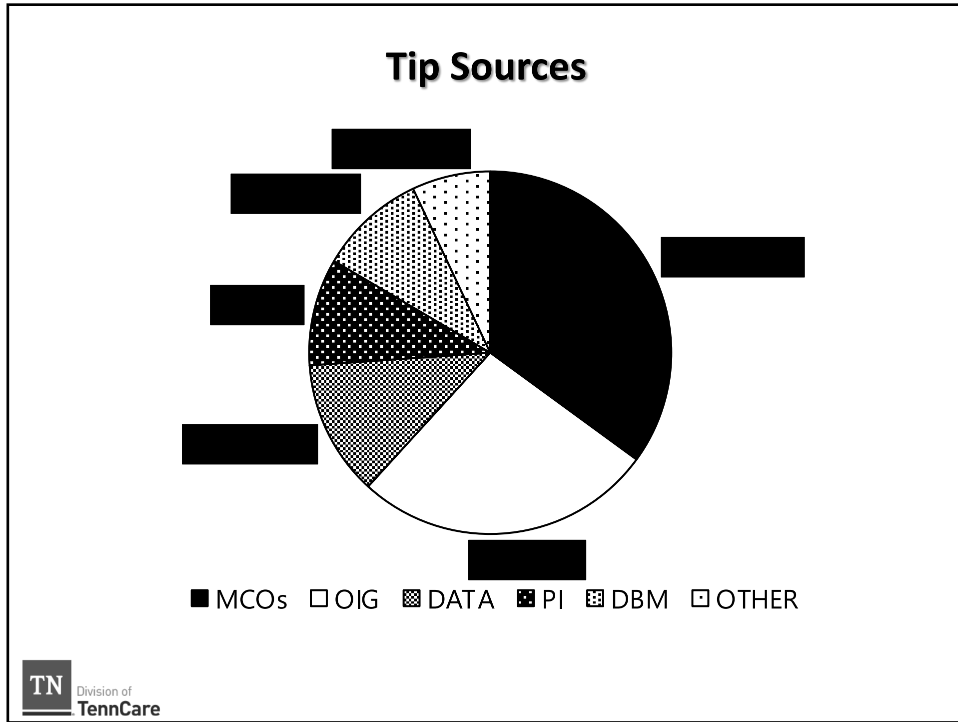
Core Functions:
- Oversight & Audit of MCO Program Integrity Functions
- Compliance with Contract/Policy
- Training and Development

5



Journey of an Investigation

6



7

Common Allegations

- Services Not Rendered
- Non-Covered Services as Covered Services
- Unbundling
- Overutilization of Services
- Upcoding
- Non-Credentialed Providers
- Medically Unnecessary Services
- Falsifying Documentation
- Double Billing
- Overlapping Services
- Cloning Records
- Time Bandits
- Transportation to Nowhere
- Services after Date of Death
- Overprescribing

TN Division of TennCare

8

Trends Identified

- Pain Clinic Models
  - Overutilization of DME (Back braces & TENS Units)
  - Frequency of Injections
  - Overuse of Urine Drug Screens/Quantitative Billing
- Overutilization and inappropriate billing of Nerve Conduction Studies
- Non-Par Providers receiving Cash for Visits
- Overprescribing of Narcotics
- Duplicative Tooth Extractions
- Inappropriate billing of Sleep Studies
- Behavioral Health documentation and licensure
- Services billed/paid but not rendered

9

Investigation Process

- Initial Triage within 3 Days of receipt of a referral
- Data Request within 2 Weeks
- Determine Scope and Review Data within 2 Weeks
- Request SVRS of Records sample within 1 Week
- Records Request due within 21 Days
- Medical Records Review within 2 Weeks
- Additional Supporting Research within 2 weeks
- Compose Referral Summary within 2 Weeks
- Present to MFCD/AG within 90 Days

10

OPI Fraud Referrals to MFCD/AG

- 46 referrals in 2018
- 60 referrals in 2019
- 52 referrals so far in 2020
- In 2019:
  - TBI, AG and OPI reached settlements with providers in excess of $50.3 million
  - MCOs identified a cost savings of $37.5 million

11

My client is being investigated…

- Process:
  - Investigation starts and records for specific patients are requested;
  - The provider has **21 days** to respond with medical records;
    - TennCare expects that any document that will support what they billed and were paid for to be submitted at this time
  - Onsite audits may be conducted without any advance notice.
    - Must Provide Medical Records that Day
    - Staff Interviews
    - Tour of Facility (Pictures)
    - Other Internal Documents Obtained
      - Staff Contracts, Protocols/SOPs, Prior Audit Reports

12

My client is being investigated…

- Recommendations:
  - Advise client to send in medical records as promptly as possible.
  - Submit well-organized records
    - Electronic format, submit separate file for each patient and name file with patient last name_first name;
    - Paper records in alphabetic order, with each patient record separated;
    - Provide details for abbreviations that are used in the medical records (especially non-standard abbreviations);
    - The more documentation, the better. If they are unsure if something is needed, just send it in; we would rather have too much than not enough.
    - Communicate with the investigator to determine if anything else is needed – be proactive during the audit process.

13

My client is being investigated…

- Recommendations:
  - Ensure providers are keeping records as required (*See* CRA A.2.12.9.14 and contractual requirements-TEN YEARS);

    NOTE: Failure to provide records can lead to suspension of payments and/or termination of Medicaid ID
  - Read the MCO manuals that outline requirements for billing requirements;
  - May want to encourage clients to hire a certified coder or have a certified coder come in every so often and randomly audit some records;
  - Ensure rendering provider and/or supervising provider is clearly documented for each service/code billed;
  - Ensure electronic records are locked as an unlocked record may be classified as an incomplete record that is easily altered;
  - Any billed tests must include test results and order for testing.

14

My client is being investigated…

- Recommendations:
  - For any timed code (mental health, therapy, etc) the in/out time or total time must be documented.
  - For ST/PT/OT, each therapy performed must be documented with in/out time or total time.
  - Total time for all types of therapy is based on face-to-face time.
  - Face-to-face is the time spent with the individual regardless of how many therapists, technicians, group or family members are present.
  - Concurrent care for therapy is not separately billable as additional time spent with patient.
  - Ensure hours do not exceed 15 hours a day for rendering providers especially involving children (6:30 am to 9:30 pm = 15 hours)
    - Most parents are not going to allow their children to have any type of outpatient therapy after bedtime
    - If therapy is provided after hours regardless of age, documentation must support the need

15

My client is being investigated…

Follow-up:

- A determination will usually be made to close or refer the case for further investigation to the Medicaid Fraud Control Division and/or Attorney General within 90 days of receipt of the medical records.
- Depending on the facts of the case, the provider may be notified of a suspension, overpayment, or action related to civil or criminal charges.

16

Administrative Actions

- Providers are presented to the TennCare Provider Review Committee (PRC) to pursue termination and/or suspension of the provider's Medicaid Number.

Reasons providers go to PRC:

- All cases accepted by MFCD (TBI) (credible allegation of fraud suspension);
- Provider fails to comply with a medical records request from the State or MCOs.
- Sanctions, convictions, exclusions, and licensures revocations.
  (Prior to PI action, MCOs are notified for network adequacy)

17

Administrative Actions

- Notice is sent to the provider with details of the action and appeal rights if action is taken by PRC
  - In suspension due to credible allegation of fraud, the notice must only set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation. 42 C.F.R. § 455.23.
- Appeals Process
  - If an appeal is filed, the appeal is set for hearing through the TennCare Office of General Counsel.
  - The appeals process is governed by the Tennessee Uniform Administrative Procedures Act and Tenn. Comp. R. &. Regs 1200-13-18.
  - Appeals are heard by an Administrative Law Judge from the Tennessee Secretary of State's office.

18

Administrative Actions

- Due to the very low burden of proof for suspensions on the basis of a credible allegation of fraud, these administrative actions are often put on hold to allow the attorney for the provider to work out a settlement agreement with the Attorney General's office.

- Note: All suspension of payment actions based on a credible allegation of fraud are **temporary** and will not continue after either of the following:
  (i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
  (ii) Legal proceedings related to the provider's alleged fraud are completed.

19

Questions?

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20