

# THE INSPECTOR GENERAL'S TOP TEN: MEDICAID RISK AREAS FOR PHYSICIANS

-2008 PHYSICIAN PRACTICE  
COMPLIANCE CONFERENCE

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## NEW YORK MEDICAID

- Biggest program and payments
- Second biggest program integrity unit-525 employees
- Biggest data warehouse-\$200 billion in claims
- Legislature, Media and Congressional attention to New York issues
- New York Legislative, Executive Branch commitment to address Medicaid program integrity

## OLD MODEL-PROSECUTION FOCUS

- FOCUS ON INTENT OF INDIVIDUAL AND ENTITY ACTORS
  - What did they do that was wrong?
  - How did they know it was wrong?
  - How do we prove that they knew?
  - How do we punish them for conduct they knew was wrong, and recover the money they obtained through wrongful behavior?

## CONSEQUENCES OF PROSECUTION MODEL

- PAY AND CHASE
- CRIMINAL FOR INDIVIDUALS, MONITORS FOR LARGE CORPORATIONS
- OBSTRUCTION IS THE EASIEST CRIME TO PROVE
- SKILL-good lawyers make huge difference
- LUCK
  - Was there a whistleblower?
  - Emails, record destruction, undercover, recorded conversations

## NEW MODEL: PROGRAM INTEGRITY-FOCUS ON REDUCING IMPROPER PAYMENTS

- What improper payments occur?
- Why do they occur?
- What systems and controls were in place (in the physician practice, at the hospital, nursing home, or managed care plan, outside professionals, payor, and enrollee) to prevent and detect improper payments?
- What improvements are required to systems and controls to prevent recurrence?
- How do we distinguish between organizations with effective systems and controls and those without?
- If they can't do it right, we don't want them in program

## PROGRAM INTEGRITY MEANS A FOCUS ON EFFECTIVE COMPLIANCE PROGRAMS

- NY-mandatory “effective” compliance programs for hospitals and snfs
- Failure to have effective compliance program is basis for exclusion
- “effective” compliance program requires disclosure to state of overpayments received, when identified
- “effective” compliance program requires risk assessment, remedial measures

## PROGRAM INTEGRITY AND COMPLIANCE REQUIRE RISK ASSESSMENT

- What are system vulnerabilities?
- What are areas of interest to State IG, CMS, OIG?
- What are recent projects and recoveries?
- Work plans, reports, websites

## PROGRAM INTEGRITY REQUIRES PROVIDER AND PROFESSIONAL COMMUNICATION

- April 2008 NY OMIG Work Plan
- October 2008 NY OMIG Annual Report for 2007
- Beginning 10/1/08, all new final audit reports will be on NY OMIG website
- Model NY compliance guidance coming for hospitals and managed care
- Voluntary NY disclosure guidelines-10/08

## PROGRAM INTEGRITY REQUIRES AUDIT FOCUS

- AREAS OF SIGNIFICANT COST WITH LIMITED PRIOR AUDIT WORK
  - Managed care
  - Hospitals
  - outpatient clinics
  - Personal care
  - Exclusion, duties of ordering physicians

## PROGRAM INTEGRITY REQUIRES AUDIT PROTOCOLS

- OHIP WRITES REGULATIONS/OMIG AUDITS TO REGULATIONS
- "WHERE IS IT WRITTEN?"
- SHARING AUDIT PROTOCOLS WITH AGENCIES AND PROVIDERS
- PROVIDING SUPPORTING DOCUMENTATION ON ADVERSE FINDINGS TO AUDITED PROVIDER

## NOT JUST OMIG-MEDICAID INTEGRITY CONTRACTORS ARE COMING-Pa. to Fla. In 2009, NY IN 2010

- Conduct post-payment audits of Medicaid providers
- Perform combination of field audits and desk reviews
- Begin with fee-for-service providers and cost report audits
- CMS: "Audits will identify overpayments, but Audit MICs WILL NOT be involved in collection of overpayments." (translation: CMS will take money from states, leave it up to states to collect from providers)

12

## CMS VIEW: State's Role with MICs

- "Vet the monthly audit list to make sure MICs are not duplicating/interfering with State activities"
- "Review draft and final audit reports"
- "Recover overpayments from providers"
- "Adjudicate appeals"
- From CMS MIC (Medicaid Integrity Contractor) Slide presentation July 2008

13

## #10-SUPPLEMENTAL/DUAL PAYMENTS

- Supplemental newborn and maternity payments
- GME supplemental payments with no encounter data

## #9-NEVER EVENTS

- Starting October 1,2008-Medicare and many Medicaid state programs
- Present on admission-where did this patient come from?Whose care were they under?
- Acquired during hospital stay
  - Reported?
  - Attending physician? Hospitalist?
  - Lab,pharmacy
  - Records integrity

## #8 HHS/OIG, CMS WORK PLAN GOALS AND ISSUES

- LOOK FOR INITIATIVES UNDER MEDICAID
- OUT IN NEXT TWO WEEKS

## #7-Credit balances

- If you have received two payments for the same service, physicians are required by law to pay Medicaid back
- Must be refunded within 30 days of receipt of reimbursement from third party
  - E.g., 18 NYCRR 540.6 (e)(4)
  - States will be reviewing major providers for credit balances

## #6-rebilling of denied, disallowed, voided claims

- Do you know what your billing system is doing?
  - Dead patients
  - Impossible claims
  - Automated rebilling

## #5 Third Party Representations

- “No other insurance”
- O payment from other insuror

## #4-Who is using your number (or your signature)?

- Pharmacies
- Home health agencies
- Outpatient facilities
- What systems do you have in place that show what you have ordered for a patient?
- Do you know what Medicaid thinks was billed using your number?
- If they are using 20,000 dead physicians, what might they be doing with yours?

## #3-Payment Error Rate Measurement (PERM)

- CMS contractor
- First claims reviewed and researched 10/08
- Please help us-flag internally for response
- Average rate in first 17 states-18%

## #2 Physicians and managed care

- Physician authorization/patient access to services (e.g., post discharge home health)
- Delays in adding patients to capitation by HMO
- Access to specialists
- Records of services/encounter reporting
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## #1-Compliance Program

- Eight requirements +
- Effective?
- Risk assessment
- Role/reporting of compliance officer
- Critical if other issues discovered
- Employee/staff knowledge
- Board knowledge/involvement
- Add to work plan for 2009

## DATA MINING TECHNIQUES

- Claims analysis-5 years, \$200 billion in claims in data warehouse
- Patient demographic feed and match-age, sex, marital status, addresses, licensing, ssns
- Electronic diagnostic and treatment feeds-ICD-9s, DRGs, key words-claims, managed care encounters, authorizations
- In-depth medical record analysis for given disease conditions using integrated health care organization systems (Bennett and colleagues, Northwestern)
- Geographic analysis for sales, patients, providers, relationships
- Modality analysis-which physicians use injectibles? Which physicians are early adopters? Which physicians use lab and physiological diagnostic tests?
- Every mining toolmaker wants to mention New York as a customer

## DATA MINING

### Where we were FFY 2007<sup>1</sup>

- New York leads the nation in reported fraud and abuse recoveries - \$136 million of \$308 million national total (second is Georgia, with \$22 million)
- Data mining drives match projects and recoveries
- Using Fraud Collections as a percentage of Total Expenditures, NY (.31%) ranks third to Utah (.48%) and Wyoming (.46%).
- Of the top 5 states in expenditures, New York's \$136 million in fraud and abuse recoveries is followed by:
  - **California**     **\$21 million**
  - **Florida**        **One of 7 states with no reported recoveries**
  - **Illinois**         **One of 7 states with no reported recoveries**

1: All slide figures as reported on CMS form 64 for FFY 2007

## DATA MINING

### Where we were in FFY 2008

- Data mining was a significant contributor to \$215 million recovery goal required by CMS contract with New York for 2008
- Pilot projects with contractors and DOH
- Expanded capabilities for out years-systems, contractors and personnel
- OMIG task force to enhance use of data mining results in audits, investigations and enforcement

## DATA MINING 2008

- PERM (Payment Error Rate Measurement)- New York is being evaluated for 2008 claims
- Average error rate in 17 states evaluated in 2007-18%
- Stratified sample of all claims
- Test-is claim supported by documentation supplied by provider upon request

## Data Mining Approaches Data Matches/Demographics

- Men having babies
- Fillings in crowns
- Deceased enrollees
- Children under 10 years old having babies
- Women giving birth every 5 months
- Women over 50 years old having babies without infertility treatments

## Data Mining Approaches

### Data Match on Providers & Networks

- Doctor P was excluded from Medicaid, but is ordering services
- Doctor in Amagansett serves only patients from Bronx.
- Every patient who goes to clinic y gets multiple prescriptions filled in pharmacy Z
- Dr. A in Rochester writes 10% of the prescriptions filled at chain pharmacy location B.
- Dr. P died in 1997, is still a referring physician
- Managed care plan Q has never paid for a mental health visit for a Medicaid member

## Data Mining Quality Tools

### Providers Not Meeting Minimum Standards

- Never events not reimbursable-New York Medicaid 10/08
- Unreported adverse events
- Unreported adverse outcomes/unanticipated deaths
- Ranking/rating facilities-audit focus
- Condition of participation failures (structure)
- Drug outcomes in populations and in facilities

## DATA MINING QUALITY TOOLS

- Interventions and Outcomes-not just claims data
- Drug, device, practice pattern outcomes
  - Epogen and cancer growth
- Off-label prescription practices
  - What drugs and devices are used for patients who do not have on-label diagnoses?
  - What works?

## Conclusion

- Building in Program Integrity is key to future of Medicaid
- Data Mining is Future in Program Integrity and Compliance
- Rich new data sources-electronic medical records, data integration
- Which tools? How to evaluate tools?
- Focus on Outcomes vs. Focus on Intent?
- Focus on Systems vs. Focus on Events?
- Measures for Data Mining in Compliance
- Relation to Enterprise Risk Management and COSO measures

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