

HCCA AUDIT AND COMPLIANCE COMMITTEE CONFERENCE MAY 20, 2010 LEARNING FROM MANDATORY COMPLIANCE

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THE CURRENT STATE AND TREND OF MANDATED COMPLIANCE

- MANDATED COMPLIANCE DISCLOSURES FOR NON-PROFITS ON IRS 990 (2008)
- MANDATED COMPLIANCE PROGRAMS FOR MEDICARE ADVANTAGE AND PART D (Prescription Drug Plans) (CMS-2008) (72 FR 68700 and program memos)
- MANDATED "CODE OF BUSINESS ETHICS AND CONDUCT" FOR FEDERAL CONTRACTORS, INCLUDING MANDATED DISCLOSURE OF KNOWN OVERPAYMENTS (2009) (FAR 52.202-13)
- MANDATED "EFFECTIVE" COMPLIANCE PROGRAMS FOR NY MEDICAID PROVIDERS, INCLUDING MANDATED REPAYMENT OF OVERPAYMENTS- (New York OMIG 2009) (18 NYCRR 521)
- MANDATED REPAYMENT OF OVERPAYMENTS (PPACA Section 6402) (2010)
- MANDATED COMPLIANCE PROGRAMS FOR NURSING HOMES AND SOME OTHER HEALTH PROVIDERS-Patient Protection and Affordable Care Act Sections 6102, 6401 (2013)

COMPLIANCE MANDATES BY COURT DECISION

- **United States v. Merck-Medco Managed Care. L.L.C.**, 336 F.Supp.2d 430, (E.D.Pa. 2004) a federal court held that the failure to have a proper compliance program which is effective under applicable legal standards and industry practices can be the basis for a False Claims Act claim. Failure to have such a plan in place can be the basis for a jury conclusion that the corporation “recklessly disregarded” its responsibility to assure that the claims were accurate.

COMPLIANCE MANDATED BY FEDERAL CONTRACT PROVISION FAR 52.202-13 (new for 2009)

- b) *Code of business ethics and conduct.*
- (1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—
- (i) Have a written code of business ethics and conduct; and
- (ii) Make a copy of the code available to each employee engaged in performance of the contract.
- (2) The Contractor shall—
- (i) Exercise due diligence to prevent and detect criminal conduct; and
- (ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.
- (3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed—
- (A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or
- (B) A violation of the civil False Claims Act (31 U.S.C. 3729-3733).

COMPLIANCE MANDATED BY REGULATION-PARTICIPATION IN NEW MEDICARE PROGRAMS (effective 2008)

- 42 CFR §422.503(b)(3)(vi)
- 42 CFR §423.504(b)(4)(vi)
- requirements for Compliance Plans
- Medicare Advantage Organizations
- Part D Sponsors

HHS/OIG-HOW DID PROVIDERS COMPLY WITH CMS' COMPLIANCE REQUIREMENTS ?

- Many sponsors' compliance plans did not address requirements relating to two elements: **designation of a compliance officer and compliance committee**, and **procedures for internal monitoring and auditing** **HHS/OIG review, 2009**
- CMS has not finalized **any** Audits of Plan Sponsors' Compliance Plans by 2010
- Because CMS has not finalized any audits of PDP sponsors' compliance plans, we do not know whether this key anti-fraud component is working at the plan level and what improvements plan sponsors can make to improve program safeguards. (HHS/OIG – testimony of Robert Vito, Regional Inspector General 3/03/10 before Senate Committee on Homeland Security)

THE NEW YORK REQUIREMENT
 "AN EFFECTIVE COMPLIANCE PROGRAM" BY 10/1/09,
 INCLUDING REPAYMENT OF IDENTIFIED OVERPAYMENTS

- Social Services Law and 18 NYCRR 521
- This requirement of a mandatory, *effective*, compliance programs for Medicaid providers, including managed care plans, is a condition of new and continued participation in the New York Medicaid program, for every Medicaid provider who receives more than \$500,000 per year from Medicaid.
- Certification by 12/31/09
- Reviews, best practices, program testing, disclosure assessment, lessons learned- 2010-2011

NEW YORK IS THE FIRST STATE
 TO LOOK FOR SYSTEMATIC WAYS
 TO EVALUATE COMPLIANCE
 PROGRAMS

- Standard: 8 elements (structure)
- Standard: certification of effective compliance program (structure)
- Standard: response to internally or externally identified improper claims (process)
- Standard: effective (outcomes)
- What is effective? "identify and prevent"
- What is effective? Identify and repay

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- First Standard: effective (outcomes)
- What is effective? "identify and prevent"
- What is effective? Identify and repay
- Look for submitted claims, not paid claims
- Look for improper claims, not fraud
- Look for binary measures
 - Dead or alive patient
 - Dead or alive ordering provider
 - Excluded provider or employee
 - Impossible care (hysterectomy on male)
 - Two places at once (in-patient and in ambulance)

SYSTEMATIC EVALUATION OF COMPLIANCE PROGRAMS

- THE DECEASED PATIENT PROJECT PLAN
 - Measurement pre-compliance: 300 claims for services to deceased patients each month (132 unique beneficiaries)
 - Open letters to providers-effective compliance program should identify and prevent billing for deceased patients-AUGUST, 2009
 - October, 2009-identify billing for deceased beneficiaries during month
 - December, 2009-letters to providers billing for apparently deceased beneficiaries
 - 2010-publish names of providers who billed for deceased patients without an adequate explanation

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- DECEMBER 1, 2009 LETTER
 - Apparent billing for deceased patients
 - Please advise:
 - Who provided service
 - Who billed for service
 - Documents supporting billing
 - Is this patient really deceased?

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- ISSUE-HOW GOOD IS MEDICAID DATA?
 - 152 providers advise that patient was alive at time of service
 - Some providers advise they are permitted to bill even though patient was deceased during month-they are right! (case management, equipment rental)
 - Can we rely on death data from our enrollment system, or from Social Security?
 - Need to import data from other systems (New York Vital Statistics)
 - Some deceased patients are born again in the recipient management system after our letters
 - When is DOD “date of death”

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- How might an improper claim have occurred?
 - Intentional conduct by provider
 - Mistake by provider (individual or systemic)
 - Identity theft
 - Identity sale
 - Family or friend conduct
 - Ordering provider conduct
 - Street scheme (with or without provider involvement?)

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- SECOND ISSUE:
- Standard: response to internally or externally identified improper claims (process)
- Did they respond to OMIG's letter?
- By due date, 1/3 of providers had not responded
- Non-responsive providers include major hospital systems
- By February 15, and multiple phone calls later, 13 non-responders
- Where is the internal compliance oversight on non-responders?

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- Standard: response to internally or externally identified improper claims (process)
- THIRD ISSUE: Was the provider's response accurate?
- Some pharmacies and DME suppliers may state that patient is alive because it is easier

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- FOURTH ISSUE: WHAT SYSTEMIC COMPLIANCE ISSUES DID STATE LEARN FROM DECEASED PATIENTS PROJECT? HOW WILL STATE ADDRESS AND COMMUNICATE COMPLIANCE ISSUES?

EVALUATING COMPLIANCE: THE DECEASED PATIENT PROJECT

- WHAT SYSTEMIC COMPLIANCE ISSUES DID PROVIDERS LEARN FROM DECEASED PATIENTS PROJECT? HOW WILL PROVIDERS ADDRESS AND COMMUNICATE COMPLIANCE ISSUES?
- FREQUENT FLYERS?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " C & C homecare was unaware that the patient was deceased at the time the service was billed to Medicaid and would have no reason to believe that the patient was deceased since the primary insurance had paid the claim". " We will advise the provider to void the claim."
- LESSON: Provider relies on payment system rather than compliance system to assure claim is accurate.

LESSONS FROM DECEASED PATIENTS PROJECT

Provider states that, " The cause of this error in billing was due to a lack of communication on the part of the early morning driver who was responsible for transporting these patients. The drivers lack of both performance and professionalism led to his termination".

LESSON: Provider blames employee for system failure. Did compliance assess risk of other improper claims related to this driver?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " Please be advised that due to a clerical error with our billing system, billing incorrectly occurred on 6/20/09 and 6/23/09. We are voiding both claims and returning the money received. We discovered, upon further investigation, that the above recipient had been a "standing order" whom we transported to and from renal dialysis treatment three times a week for several years. We placed a "Hold" on this recipient which was inadvertently missed by the billing clerk and two claims were billed in error".
- LESSON: Provider blames employee for system failure- How often did the "hold" system not work?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " Patient's son called to request refill for the above date of service and the signature was also the patient's.
- LESSON: Provider will insist on "fact" which cannot be true, if death data is accurate.

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " This letter is in response to the communication we received in mail regarding prescription claims belonging to a deceased client, _____. He has been a customer of our pharmacy since 2004. The claims were adjudicated on the request of home aide L_____ W_____. (Client) has home aid to pick up his medications. Sometimes he pick-up himself and other times his home aid or family members pick up the medications. We did not get any reimbursement for the claims mentioned in your letter. So, we will not be able to void any claims". Note: All claims submitted for this recipient were denied
- LESSON: Providers are not paying attention to denied claims, and are losing revenue as a result
- LESSON: some individuals dealing with terminal patients have figured out that providers are not paying attention to denied claims
- Compliance issue: who should address acts of home health aide?

LESSONS FROM DECEASED PATIENTS PROJECT

home health aide had requested her prescription and scheduled a delivery before the week of Thanksgiving. On 11/21/09 we have filled her prescription and attempted to call to confirm without success. We called again on 11/30/09 and again without success. On 12/4/09 her prescriptions were returned to stock and prescriptions were to be voided and reversed. Due to rare occurrence, the transmission line was down and technician had voided all prescriptions on 11/21/09 without getting a proper reversal authorization. Our compliance officer had failed his responsibility to follow up on this isolated incident".

- LESSON: Provider blames compliance officer for system failure.
- Compliance issue: how do we know that this was an "isolated incident"

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " Investigation into the three claims has revealed that all were for HIV 1 and 2 antibody screening assays conducted by the Public Health laboratory on the dates of service noted. Further investigation revealed that the specimens had been sent to the PHL by the Office of the Chief Medical Examiner of ___ City (OCME) as part of its duty to determine cause and manner of death. Thus, all three individuals were indeed deceased at the time the laboratory tests were conducted. On December 13, 2009, DOHMH ceased submitting all PHL and other certain other clinical services claims for reimbursement to third-party payors via Dataline. This decision was made upon my recommendation as the agency's Compliance Officer. My recommendation was based on a review of Datalines' billing processes and procedures by DOHMH's Office of Medicaid and Medicare Revenues, as well as my own review of the data systems and procedures in use. It bears noting that no evidence of fraud in any way was revealed from these internal reviews. It was clear, however, that processes developed to maximize 1990's technology and environment were no longer suitable". (Note: All three claims were denied)
- COMPLIANCE LESSON: use information from identified errors to evaluate system and develop changes

LESSONS FROM DECEASED PATIENTS PROJECT

- Called 717-761-xxxx was transferred to customer service by the operator. Called Bradlee at 717-214-xxxx a contact from the Dec 09 mailout for one of the Rite Aid responses. She asked me what store numbers they were and where they were mailed. She asked me to fax the letters to her since she never received them from the stores. I faxed them to 717-214-xxxx. She said she will be the one to respond to them.
- Compliance lesson: In some organizations, no effective process exists to bring compliance issues to compliance function

LESSONS FROM DECEASED PATIENTS PROJECT

- The provider states that, " On October 11, 2009, our home attendant Juana A. was scheduled to work for _____ for 3 hours from 10:00 AM to 1:00 PM and actually worked from 10:00AM to 2:00 PM. Her action created an automated billing from Sandra Technology for _____(other patient). We were incorrectly informed that the client (other client) had died in the hospital on October 11, 2009 and we closed the case on October 12th, 2009. Because the wrong date of death was originally initialled, these hours were erroneously billed under (other patient). Our records have been changed to reflect the actual date of death of October 10, 2009 with a close date of October 11, 2009. We are in the process of recouping the 4 hours from the home attendant and we also voided our billing for (other patient) for service date 10/11/2009 on April 9, 2010.
- COMPLIANCE LESSON-automated billing system not accurate

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " I did not, at any point, provide any services to the patient in question, nor did I submit claims to Medicaid, at any point in time, regarding services provided to this recipient. In fact, I did not provide any services to any resident at Rehabilitation Center after 10/30/08. I worked at Rehabilitation Center from 8/2004 and from 5/4/2007 to 10/30/2008 as an employee of X Psychological Services. As part of my contract agreement, while I was in their employ, X submitted claims to Medicaid on my behalf; I received compensation for my services directly from X. As I did not provide services to the resident in question, I cannot attest to whether or not the resident in question was deceased during or after the dates of service listed in your fax. I am concerned that there is either an error in record keeping, or worse, that fraudulent claims have been submitted using my name and Medicaid identification number without my knowledge or consent" (Note: the claims in question were denied)
- Compliance lesson: focus on billing entities as well as named providers

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " After investigation of the claim for _____, claim date 11/24/09, we agree with your finding that the patient was deceased on the date of service. Here are the facts that led to this incorrect claim and the steps that we are taking to insure that this does not occur again. The nurse was on her way to the patient's house when she received a telephone call stating that the patient had passed away. Because we have an electronic medical record system, the nurse had pre-scheduled this visit and selected her activity as a chargeable visit. By the time she returned to the office later that day, she had forgotten that she had scheduled the visit with chargeable activity in our software system and subsequently did not charge it to an ineffective visit. We have voided the claim".
- COMPLIANCE LESSON-charging system pre-selects "chargeable visit"-how fixed?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " This error was made due to gross negligence of the biller, who was present at the time the order was issued. We have made great strides to correct this error, and have had our software provider retrain the billing staff. The billing department also now bills in a multistep process. This process allows for several opportunities to double check all information in the claim prior to submission. It should also be noted that all person who worked in the capacity as Medicaid and Medicare billers in 2009 are no longer employed by our company".
- Compliance lesson: Where are they now?
- Compliance lesson: What about old billing?

LESSONS FROM DECEASED PATIENTS PROJECT

- Provider states that, " In September of 2009, we started a new consumer X into our Day habilitation program and in the documentation we received was the incorrect Medicaid number. The Medicaid number we accidentally used was for Y. We have corrected the Medicaid number for X that was in our program. We thank you for the information and assistance in the correction".
- Compliance Lesson: how many billings for Y before his death? What did you do about them?

LESSONS FROM DECEASED PATIENTS PROJECT

erroneous claim to Medicaid for patient Z. This patient was admitted to Peninsula Medical Center in August, 2009, and after an extensive hospitalization with multiple complications, he expired on 10/13/09. Unfortunately, a clerical error occurred during my billing process and the claim I submitted included a request for payment for service date 10/14/09. Upon notification of this error, I instructed my biller to void the claim for 10/14/09".

- Compliance lesson: how did this error occur? Who was the cleric?

MANDATORY COMPLIANCE

- Standard: 8 elements (structure)
- Standard: certification of effective compliance program (structure)
- Standard: response to internally or externally identified improper claims (process)
- Standard: effective (outcomes)
- What is effective? "identify and prevent"
- What is effective? Identify and repay
- Systemic approach: what happened? Why did it happen(root cause) What does it tell us about our organization, its system, and its compliance

GETTING READY FOR MANDATORY COMPLIANCE

- What systems tell you about compliance weakness before government does?
 - Denied claims (with denial codes)
 - Resubmitted claims with different information about same patient
 - Patient complaints in billing process
 - Reported errors
 - Internal controls and reviews

COMPLIANCE: TWO BIGGEST WEAKNESSES OF COMPLIANCE

- “However, many Medicare Part D sponsors’ compliance plans did not address requirements relating to two elements: designation of a compliance officer and compliance committee, and procedures for internal monitoring and auditing”
- Compliance must have a board supported structure and person responsible for process
- Internal auditing and monitoring is essential to effective compliance program-reactive to specific complaints is not enough

FREE STUFF FROM OMIG

- OMIG website-WWW.OMIG.State.ny.us
- Mandatory compliance program-hospitals, managed care, all providers over \$500,000/year
- Over 1500 provider audit reports, detailing findings in specific industry
- 66 page work plan issued 4/20/09-shared with other states and CMS, OIG (new one coming as soon as NY 2010 budget is finalized)
- Listserv (put your name in, get emailed updates)
- New York excluded provider list

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