Managed Care Fraud Enforcement and Compliance

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Overview

• Understanding and Developing an SIU in a Managed Care Environment

• Understanding Regulatory Challenges for a Managed Care Environment

• Managed Care SIU and Law Enforcement-Same Goals But How To Get There
WellCare Health Plans, Inc.

Company Snapshot

OUR PRESENCE

All numbers are approximations and are as of March 31, 2016

WellCare Health Plans, Inc.

At WellCare, our members are our reason for being.
We help those eligible for government-sponsored health care plans live better, healthier lives.

Emphasis on lower income populations and value-focused benefit design

Communication among members and providers to improve outcomes

Focus on preventive care including regular doctor visits

Community-based solutions to close gaps in the social safety net

WellCare Health Plans, Inc.

Founded in 1985 in Tampa, Fla.:
- Serving 3.7 million members nationwide
- 365,000 contracted health care providers
- 68,000 contracted pharmacies

Serving 2.4 million Medicaid members, including:
- Aged, Blind and Disabled (ABD)
- Children’s Health Insurance Program (CHIP)
- Family Health Plus (FHP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

Serving 1.4 million Medicare members, including:
- 328,000 Medicare Advantage members
- 1 million Prescription Drug Plan (PDP) members

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid)
- Health Care Marketplace plans
- Managed Long Term Care (MLTC)

Spearheading efforts to sustain the social safety net:
- The WellCare Community Foundation
- WellCare Associate Volunteer Efforts (WAVE)
- Advocacy Programs

Significant contributor to the national economy:
- A FORTUNE 500 and Barron’s 500 company
- 7,000 associates nationwide
- Offices in all states where the company provides managed care

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**Mission/Vision**

Ensure development of Mission/Vision Statements and ensure communicated and understood by associates not just in SIU but across the company.

**Mission:** To identify, investigate and correct fraud, waste and abuse (FWA) committed against the plan and its stakeholders, by anyone, including, providers, employees, and members.

**What an SIU does:**
- Detect and deter fraudulent claims
- Identify and remedy provider overutilization
- Terminate providers who have defrauded or abused the system
- Refer for regulatory inquiry and criminal prosecution those who defraud the system
- Work with our pharmacy benefit manager to identify and remedy pharmacy fraud
- Provide fraud awareness training to employees, vendors and providers

**Fraud, Waste, and Abuse Definitions**

**Fraud**
- Fraud is an intentional deception, misrepresentation, or omission made by someone with knowledge that may result in benefit or financial gain.

**Abuse**
- Abuse is sometimes defined as a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.
- There is no “bright line” distinction between fraud and “abuse.” “Abuse” can be thought of as potential fraud, where the intent of the person or entity may have been unclear.
- Key Question: Does the conduct result in excessive or undue reimbursement or benefit?

**Waste**
- Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources.
- Waste does not necessarily generate financial gain, but almost always reflects poor management decisions or practices or ineffective or lax controls.
Member Fraud Examples

Doctor Shopping
• A member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotics or other prescription drugs
  Doctor shopping may be indicative of an underlying scheme, such as stockpiling or resale on the black market/street

Theft of ID/Services
• An unauthorized individual uses a member’s Medicare/Medicaid card to receive medical care, supplies, pharmacy scripts, or equipment; it’s often a family member or acquaintance

Provider Fraud Examples

Billing for Services not Rendered
• Billing for individual therapy, where only group therapy was performed
• Billing for Durable Medical Equipment (“DME”) supplies never delivered
• Billing for “phantom” supplies or services never rendered
  • For example, billing for a practitioner’s visit to a nursing home for services rendered to all or nearly all residents, even though the practitioner did not provide services to all residents.
Provider Fraud Examples

Fraudulently Justifying Payment
• Misrepresenting a diagnosis in order to justify payment
• Falsifying documents such as certificates of medical necessity, plans of treatment and medical records to justify payment

Kickbacks
• Referring patients for diagnostic tests in exchange for money
• Using a specific wheelchair manufacturer because the individual selecting the wheelchair received an “incentive” payment for the selection

Provider Fraud Examples

Rendering and Billing for Non-medically Necessary Services
• Performing Magnetic Resonance Imaging with contrast despite the contrast not being indicated or medically necessary
• Ordering higher-reimbursed, complete blood lab tests for every patient although more specific or limited tests are indicated
Provider Fraud Examples

Upcoding - Billing a Higher Level Service than Provided

- Reporting CPT code 99245 (High Level Office Consultation); yet, services provided only warranted use of CPT code 99243 (Mid level Office Consultation)

- Reporting CPT code 99233 (High Level Subsequent Hospital Care); yet, services provided only warranted use of CPT code 99231 (Lower Level Subsequent Hospital Care)

Provider Fraud Examples

Unbundling - Separate Pricing of Goods and Services to Increase Revenue

- Billing separately for a post-operative visit; however it is included in a global billing code

- Billing a series of tests individually instead of billing for a global or “panel” code

Billing for Non-Covered Services

- Billing for non-covered services as covered services (e.g., billing a rhinoplasty as deviated-septum repair)
Provider Fraud Examples

Provider Prescription Drug Fraud

- Operating a “pill mill” by overprescribing opioids and high-cost drugs to be sold illegally, with the prescribing provider receiving a share of the profits
- Diluting or illegally importing drugs from other countries (e.g., cancer drugs)
- Falsifying information in order to justify coverage for higher-cost medications

More Provider Fraud Examples

Pharmacy Fraud

- Pharmacy increases the number of refills on a prescription without the prescriber’s permission
- Pharmacy dispenses expired drugs
- Pharmacy processes services not covered under the Over-the-Counter (OTC) benefit
- Pharmacy splits prescriptions, such as splitting a 30-day prescription into four 7-day prescriptions to get additional copays and dispensing fees
- Pharmacy bills for prescriptions which are never picked up
- Pharmacy re-dispenses unused medications which have been returned without crediting the return
Provider Fraud Examples

Overbilling or Duplicate Billing

- Billing a patient more than the co-pay amount for pre-paid services or services paid in full by the benefit plan under the terms of a managed care contract
- Waiving patient co-pays or deductibles and overbilling the insurance carrier or benefit plan
- Billing Medicare or Medicaid as well as the member or private insurance for the same service

Real Life Example


Between May 15, 2008 to December 31, 2013, Jennan and Dr. Chen knowingly submitted or caused to be submitted false and/or fraudulent claims to Medicare for physical therapy services.

Specifically, OIG alleged these claims were false and/or fraudulent for one or more of the following reasons:
1. Physical therapy services were not provided or supervised by the rendering provider;
2. Group services were billed as one-on-one provider-patient physical therapy services;
3. Services were performed by unqualified individuals; and/or
4. Claims for time-based physical therapy services did not accurately reflect the actual time spent performing the services.

* Source: https://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp#CMP2015031203
Sources of Regulation - Medicare

There are multiple sources of laws and regulations which include but not limited to:

- Federal statutes and regulations governing Medicare Advantage Plans (42 C.F.R. Part 422)
- The Medicaid Managed Care Manual
- The Medicare Managed Care Manual
- State Contracts, Amendments, P&P Manuals
- State Statutes and Regulations
- CMS guidance documents and directives, such as
  - Guidance documents issued through the Health Plan Management System (“HPMS”)
  - Directives and guidelines on Medicare Reporting Requirements
  - Annual call letter requirements for bid submissions

Laws Regarding FWA (Cont’d)

- Civil Monetary Penalties Law (CMP) which imposes administrative fines or CMPs for many types of illegal or unethical conduct. CMPs can also be imposed for violating healthcare laws such as the Anti-Kickback Statute and the False Claims Act in addition to the penalties found in those laws.
- Beneficiary Inducement Statute which prohibits remuneration or inducements to beneficiaries which the benefactor knows or should know is likely to influence the beneficiary’s choice of a provider or plan
**Laws Regarding FWA (Cont’d)**

- Deficit Reduction Act was designed to eliminate fraud waste and abuse in federal healthcare programs by granting states the flexibility to modify their Medicaid programs to make reforms. It also established the Medicaid Integrity Program and expanded the False Claims Act to the states.

**Penalties for Non-Compliance**

Each of these laws carry their own individual provisions for failure to comply. Provisions which may be multiplied depending on the nature of the violation.

Other consequences for non-compliance include sanctions and exclusion from healthcare programs.

To help you understand these penalties and the consequences of non-compliance - the next few slides summarizes the requirements, prohibitions, and the penalties for non-compliance (examples included).
### Penalties for Non-Compliance

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<th>Law</th>
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<td><strong>Criminal Fraud Statutes</strong>&lt;br&gt;• Submission of False Claims&lt;br&gt;• Mail Fraud&lt;br&gt;• Wire Fraud&lt;br&gt;• Health Care Fraud&lt;br&gt;• Obstruction of Justice</td>
<td>• Knowing and willful compliance violations, depending on their severity, may cause your company to violate several general criminal statutes that make it a felony to defraud Medicare and Medicaid.&lt;br&gt;• The fraud can be punished differently and the penalties will vary depending on whether the fraud is committed:&lt;br&gt;– Through the mail, phone or over the Internet; or&lt;br&gt;– By trying to conceal illegal facts from being learned by government investigators.</td>
<td>• Large criminal fines and penalties&lt;br&gt;• Prison sentences of up to 20 years for individuals</td>
<td>• Making false submissions to a state for Kick payments&lt;br&gt;• Falsifying reports of costs submitted to states to increase premium payments for members&lt;br&gt;• Up-coding encounter data for higher risk adjusted member premiums</td>
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<td><strong>False Claims Acts (&quot;FCA&quot;)</strong>&lt;br&gt;• Federal&lt;br&gt;• State</td>
<td>• These are general fraud statutes that aid federal and state governments in combating and recovering losses they suffer due to fraud in Medicare and Medicaid programs.&lt;br&gt;• Prohibit the knowing submission of false or fraudulent claims to the government for payment or the knowing concealment of a repayment &quot;obligation,&quot; such as an overpayment.&lt;br&gt;• Allow &quot;whistleblowers&quot; to bring suits on behalf of the government in exchange for a portion of the fraud recovery.</td>
<td>• Damages of up to 3 times the amount of damages sustained by the government because of the fraud&lt;br&gt;• An additional penalty of between $5,500 and $11,000 per false claim submitted (federal)&lt;br&gt;• State penalties vary</td>
<td>• Submitting a bid package that contains false data in order to receive a higher rate&lt;br&gt;• Certifying to the accuracy of a reconciliation report knowing that the data are inaccurate to avoid having to repay overpayments</td>
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<td><strong>CMS Intermediate Sanctions</strong></td>
<td>• Medicare regulations provide CMS with the power to impose penalties and sanctions if your company does not comply with all laws, regulations and contract requirements that apply to its Medicare plans.&lt;br&gt;• Sanctions may be imposed for, among other things:&lt;br&gt;– Misrepresenting information that it furnishes to CMS, to an enrollee, or to a provider;&lt;br&gt;– Failing to provide medically necessary items and services to members;&lt;br&gt;– Discriminating among enrollees on the basis of their health status; and&lt;br&gt;– Violating marketing rules.</td>
<td>• Suspension of your company’s ability to enroll beneficiaries in its Medicare plans&lt;br&gt;• Monetary fines&lt;br&gt;• Termination of your Medicare contracts</td>
<td>• Purposely disenrolling members from a plan based on health status&lt;br&gt;• Purposely denying covered health services for members</td>
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<td><strong>Anti-Kickback Statute (&quot;AKS&quot;)</strong>&lt;br&gt;• Federal&lt;br&gt;• State: states have their own Anti-Kickback Statutes</td>
<td>• Prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value (also called “remuneration”) in return for, or to induce someone to:&lt;br&gt;– Refer patients for services or for the purchase of items reimbursed by any federal health care program; or&lt;br&gt;– Arrange, recommend, or order any item or service reimbursed by any federal health care program.&lt;br&gt;• &quot;Safe harbors&quot; apply that immunize certain arrangements from criminal and civil prosecution.&lt;br&gt;• If you have specific questions about whether a business activity complies with the AKS, please call your Compliance Hotline or the Legal Department.</td>
<td>• Fines of up to $25,000 per violation&lt;br&gt;• Felony conviction and up to 5 years in prison&lt;br&gt;• Additional civil penalties of up to $50,000 for each violation plus up to three times the total amount of remuneration&lt;br&gt;• Exclusion</td>
<td>• Providing gifts or cash incentives to members in exchange for enrollment&lt;br&gt;• Paying physician offices for enrolling patients in your health plans&lt;br&gt;• Accepting payments from vendors in exchange for using services</td>
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| **Exclusion from Federal/state Health Care Programs** | • If an associate, officer, contractor or agent is convicted of violating federal or state health care laws, the government can bar your company from participating in federal health care programs.  
• Offenses that can lead to exclusion include:  
  – Felony convictions related to the delivery of an item or service under federal or state health care programs;  
  – Felony convictions relating to health care;  
  – Violations of the CIA; and/or  
  – A conviction related to the obstruction of an investigation.  
• An excluded entity or individual must apply for reinstatement if the entity or individual wishes to again participate in any federal health care programs. The OIG has the authority to deny reinstatement requests. | • Suspension of your company’s ability to bill or receive any reimbursement from Medicare and Medicaid  
• If your company has discovered that an Associate is excluded, the Associate’s employment should be terminated  
• An Associate’s conviction for health care fraud requires the OIG to exclude that Associate from participating in federal health care programs  
• Determine if your company will terminate the Associate once he or she is excluded | |
| **Civil Monetary Penalties ("CMP") Law** | • The government, through the OIG, may impose administrative fines, referred to as CMPs, on your company for many types of illegal or unethical conduct, such as:  
  – Making payments to induce Medicare or state health care program beneficiaries to select your company as their plan;  
  – Submitting a claim to the government for a service not rendered or for members not enrolled in a plan; and  
  – Failing to promptly return a known overpayment in the reconciliation process.  
• CMPs can also be imposed for violating other health care laws, such as the federal AKS and the Federal False Claims Act, in addition to the fines and penalties found in those laws. | • Fines of up to $50,000 per violation  
• Treble Damages (3 times the amount claimed under each false claim, or 3 times the value of each bribe, in the case of a kickback)  
• Refusing to enroll a Medicare recipient due to the individual’s health status  
• Hiring an Associate who has previously been excluded from participating in federal health care programs | |

SIU Structure-Things to Consider

- What kind of staff?
  - Experience (degree or equivalent; health care/managed care)
  - Certifications (required or preferred; which ones-ACFE, AHFI)
- Who does what portions?
  - Recovery
  - Operations
  - Pharmacy
  - Vendors
- How will the SIU execute?
  - Anti-Fraud Plans
  - P&Ps
- What kind of reporting is needed internally and externally?
  - Case Management System
    - What to report; how and to whom in the organization
    - Flexibility; Systems capability
  - State reporting-metrics
  - Definitions
  - Timing Variances (monthly, quarterly, annual, adhoc)
Special Investigations Unit (SIU)

- Primarily responsible for identifying, investigating and reporting FWA

Key components of the SIU Team:

- **Management**: Strategy; day-to-day guidance; supervision of SIU staff
- **Investigators**: Resolve FWA allegations (with coding auditors and nurse)
- **Senior Analyst**: Proactively identifies FWA utilizing data analysis software
- **Medical Coders/Reviewers**: Review and analyze medical records and coding
- **Case Information Coordinators and Business Analysts**: Case referrals; case management system; anti-fraud hotline; reporting responsibilities
- **Medical Directors / Other SMEs**: Consult on investigations
- **Regulatory Affairs**: Anti-fraud regulatory and contractual requirements

*** Regulatory impacts-in state; FTE; X staff per YY Membership ***

Internal Partnerships

- Provider Relations
- Provider Contracting-state; cap v non-cap; records allowance
- Legal
- Finance
- Regulatory/Markets
- Government Affairs
- Claims/Encounters
- Recovery Department
- Pharmacy-include Lock In Programs
- Vendor Relations
- UM/CM/Medical Directors
**Training/Education**

**Internal**
- Training for SIU Staff (Onboarding; Continuing Education)
- FWA Training (At new hire/Annually)
  - All Staff
  - Contractors
  - FDR
- False Claims Act; Deficit Reduction Act; Anti-Kickback Statute
- Program Integrity/Compliance (States blending)

**Externally**
- False Claims Act; Deficit Reduction Act; Anti-Kickback Statute
- Providers
- Vendors

**Communication**

**Internal**
- Branding
- Webpage
- Homepage

**External**
- Member Handbooks
- Provider Handbooks
- Websites
- Letters/Communications (EOMBs)

**Hotline (in-house vs outsourcing)**
- Recommend Outsourcing—Anonymous, 7/24/365; Web-capability
- Reporting/Tracking

***Ensure everyone knows how to report *****
Market Collaboration Meetings

• Regulatory
  – Onsite presence v corporate site; challenges managing WFH; offsites vs. onsite collaboration
  – Capability to conduct onsites
  – Capability to meet with regulators
  – Shifting culture to broaden “Program Integrity”
• RFPs/Contracts/Amendments
  – Shift
• Purpose/Value- Two-way street; buy-in; transparency; collaboration; sensitive/confidential info Identified

Conflict Points-
• FWA vs. Key Contracted Provider
• Competing savings recorded w/in organization
• Resources/Assistance

SIU Process

• An SIU should use a multi-faceted approach to identify and pursue potential FWA to include, but not limit to:
  • An education and awareness training program to maximize employee, business partner, and downstream entity referrals to develop tips regarding possible FWA;
  • Investigating referrals from anyone, including employees, business partners, law enforcement agencies and providers; and
  • Utilize a combination of analytical tools, clinical expertise, and investigative knowledge to identify potential FWA.
  • Establish baseline data to enhance efforts to recognize unusual trends or changes in utilization patterns.
• The SIU will commence an inquiry within **X** days of the referral of the matter to the SIU.
• Document matters into a secure case management system.
Failing to Timely Report Provider Fraud & Abuse

- Medicaid health plans are required by many state laws and state health plan contracts to report to respective state Medicaid programs any fraud and/or abuse by healthcare providers. This is true even if the fraud and/or abuse could not have any adverse financial impact on the state’s Medicaid program.

- For example, Florida law requires Medicaid managed care plans to:

  409.91212 Medicaid managed care fraud.—
  (1) Each managed care plan . . . shall adopt an anti-fraud plan addressing the detection and prevention of overpayments, abuse, and fraud relating to the provision of and payment for Medicaid services and submit the plan to the Office of Medicaid Program Integrity within the agency for approval. . . .
  (6) Each managed care plan shall report all suspected or confirmed instances of provider or recipient fraud or abuse within 15 calendar days after detection to the Office of Medicaid Program Integrity within the agency. At a minimum the report must contain the name of the provider or recipient, the Medicaid billing number or tax identification number, and a description of the fraudulent or abusive act. The Office of Medicaid Program Integrity in the agency shall forward the report of suspected overpayment, abuse, or fraud to the appropriate investigative unit, including but not limited to, the Bureau of Medicaid program integrity, the Medicaid fraud control unit, the Division of Public Assistance Fraud, the Division of Investigative and Forensic Services, or the Department of Law Enforcement.

Failing to Timely Report Provider Fraud & Abuse, cont.

  - Florida’s Bureau of Medicaid Program Integrity (MPI) discovered that Humana did not report to MPI “all suspected or confirmed instance of provider or recipient fraud or abuse” within 15 days after detection. The alleged untimeliness ranged from 33 days late to 536 days late.
  - MPI issued two adverse action letters to Humana on August 9, 2011:
    - The first letter alleged a statutory violation and imposed a statutory fine of $1,000 per calendar day for each violation, which MPI alleged amounted to $2,732,000.
    - The second letter alleged a contractual breach and imposed a contractual civil monetary penalty of $200 per day for each violation, which MPI alleged amounted to $660,400.
Humana settled and agreed to pay $3,225,000!

SIU Allegation Sources

Reactive complaints
- Anonymous
- Members
- Providers
- Regulators
- SIU FWA Hotline
- Associate referrals

Proactive data analysis
- Data Analysis Tool
- Articles/News
- HealthCare Fraud Sources
  - NHCAA; ACFE; HCCA; HFPP
  - OIG Workplan
  - CMS
- Industry – AHIP, CMS, etc.
Intake

Sources
- Hotline- tied to MEOBs; Provider/Member documents
- Internal Reporting chains (email, in-person etc.)
- PBM
- Triage (±s when/what to advance)
- Tie into Case Management System
- Case Management System-Functionality
  ✓ Reporting
  ✓ Monitoring
  ✓ Repository
  ✓ Security
  ✓ Controls for access

SIU Case Prioritization

- Triage and Prioritize. The SIU team preliminarily assesses the matter and enter the case priority in our case tracking system in order to pursue the cases with the highest impact of potential FWA.

- Examples of prioritization:
  - High – Cases/allegations having the greatest program impact which would include: patient abuse or harm, multi-state fraud, high dollar impact of potential overpayment, likelihood for an increase in the amount of fraud or enlargement of a pattern, cases with an active payment suspension, etc.
  - Medium – Cases/allegations not at the level of a high priority, may be a case active with law enforcement or regulatory agency and SIU told to stand down, cases in recovery status, multiple complaints against subject but lower dollars involved, etc.
  - Low – Cases/allegations not at the level of a high or medium priority, may be low dollars involved and had no or few prior complaints, etc. All cases being prepared for closure should be a low priority.
Allegation – Medical

**Medical Case - Investigative Actions**

- Contact Referral Source/Complainant
- Complete referral to State – Note: State requirements differ
- Research prior complaints against subject
- Research corporation records, state licensure, and disciplinary issues
- Conduct internet research regarding subject/managing employees, background information, provider/facility reviews, map of the location
- Search for Subject on the HHS-OIG exclusions list
- Review NPI Registry for provider
- Research claims system for provider/member effective date and/or termination date, and credentialing
- Run claims data in claims system and/or data analytics tool
- Send member service verification letter
- Complete and mail medical record request letter
- Send records for coder and/or nurse review
- Calculate and issue overpayment notice

Allegation – Pharmacy

**Pharmacy Case - Investigative Actions**

- Contact Referral Source/Complainant
- Complete referral to State – Note: State requirements differ; If Medicare and “suspected” fraud, complete referral to MEDIC
- Research prior complaints against pharmacy and or recipient
- Identify if recipients qualifies for pharmacy “Lock-Out” program
- Research corporate records, state licensure, and disciplinary issues
- Conduct internet research regarding subject/managing employees, background information, provider/facility reviews, map of location
- Search for provider on the HHS-OIG exclusion list
- Review NPI Registry for provider
- Review pharmacy/member claim billings report to identify case allegation and or billing trends and patterns and/or run in data analytics tool
- Send member service verification letter
- Complete and mail medical record request letter
- PBM will adjust claims if needed
SIU Investigative Actions

- The SIU should pursue reactive and proactive investigations to either corroborate the allegations or determine them unfounded. The actions should include but not be limited to:
  - Data analysis to identify outlier billing patterns
  - Public record reviews – state licensure, state disciplinary actions, corporation records, etc.
  - Partnership systems search – National Healthcare Anti-fraud Association SIRIS, Healthcare Fraud Prevention Partnership
  - Pull a valid random sample based on the allegation (i.e., top code billed, claims with excessive codes, etc.)
  - Internal systems review - credentialing file, provider contract, prior authorizations, etc.
  - Conduct member interviews
  - Provider onsite audit
  - Request and review medical records by coder, nurse, and/or medical director

- The SIU should timely report suspected FWA. Once a determination has been made that the target party has engaged in FWA, appropriate remedial action should be pursued, which depends upon the misconduct at issue. Also timeliness for reporting varies by state. Document, Document, Document!

Reactive FWA Investigations

- Inquiries typically commence within 14 days of referral to the SIU
- Initial investigative actions include obtaining sample of relevant records
- Examples of records pulled by investigators
  - Provider top CPT/ICD 9 codes
  - Charts, Trending analyses, drug profiles, medical records and prescriptions
  - Payment records
  - Provider ID, Vendor ID, credentialing, Member ID (incl. address and contact information), eligibility span, PBM prescription data
  - Copy of provider’s license of state of issue, registered Disciplinary actions, NPI (National Provider ID)
  - NHCAA/SIRIS search and reporting
  - Division of Corporation listing
  - Provider and Vendor contracts
Proactive Investigations

- SIU should use a variety of proactive investigative measures to identify and pursue potential FWA

- Information sharing regarding schemes detected in the industry
  - Review of law enforcement reports or other publicly reported information
  - Partnerships with State and Federal agencies
  - Member of the National Health Care Anti-Fraud Association (NHCAA)
  - Member of the Healthcare Fraud Prevention Partnership (HFPP)

- Targeted claims queries to identify suspicious activity or unusual patterns
  - Examples: Visit trend analysis; provider up-code checker; hospital stay with no professional services; bell curve analysis; abnormal utilization
  - Results: Up-coding; unbundling; misuse of modifiers; unusual CPT codes; double billing; unreasonable service time billed in a day
  - If suspicious activity identified, expanded investigation is initiated
  - Recently purchased STARSSolutions (predictive algorithm)

Data Mining

Examples of areas to conduct data drill down:
- Outliers
- Upcoding
- Time Bandits
- Service Profiles
- Unusual Patterns
- Doctor Shopping
- Follow the Money
- Peer Comparisons
- Duplicate Payments
- Inappropriate Code Combinations
- Top Controlled Substance Prescribers
FWA Detection, Prevention, Investigation and Case Management

- Lead Generation
- High Impact rules and Predictive Analytics
- Examine the big Picture
- Automated Detection of Suspicious Behavior

- Case Documentation
- Workflow Management
- Workload Balancing
- Financial & Case Reporting

- Post and Pre Payment Review Services
- Consulting: P&P, Best Practices, Audit Prep, etc.

- Pre-Payment Intervention
- Integrated with post-payment review
- Targeted prepayment review for a more effective program

Lead generation through rules and predictive analytics

- Automated Overpayment Identification
  - Identifies aberrant billing patterns using multivariate analyses
  - Flags suspect providers, members, and claims
  - Scores leads for prioritization

- High-impact Rules/Algorithms
  - Combines clear-cut known schemes with Predictive Analytics
  - Cross benefit analysis between facility and professional and professional and Rx
  - Taylor rules based on your outcomes

- Claim Comparison Against the “Big Picture”
  - Compares billing patterns over time
  - Compares across all claim types
  - Compares providers within peer groups
  - Measures potential overpayment against universe of payment

- Comprehensive Reporting
  - Summarizes and formats findings in investigative templates
  - Includes Potential Exposure reports for analysts and management
**STARS Informant**

Follow the lead wherever the investigation takes you next
- After the lead is generated by STARS Sentinel or received from another source
  - Use STARS Informant to explore the allegation
  - Conduct ad hoc data analysis
  - Collect data and reports to support the investigation
  - Generate random samples

- Fill law enforcement data requests
  - Empowers analysts as they probe to:
    - Validate
    - Investigate
    - Research

STARS Informant is the next generation of STARS®

**STARS Commander**

Command Center for Fraud Investigation Case Management
- Put all suspects (from internal and external sources) under inventory control
  - Collect, organize, and inventory all caseload and gain new perspectives
- Assign (and re-assign) workload to staff members
- Monitor timeliness, generate alerts, follow progress
- Measure dollars at risk, overpayment demands, recoveries, the cost of case development
- Reinforce the value of SIU, Audit, and other cost-recover cost-avoidance units
STARSSolutions – Scheme Analysis Example

Sentinel Provider ID: 1720042252
Sentinel Name: FALASCO NORBERT M
Specialty: PEDIATRICS (PED)
Sentinel Specialty: Pediatric medicine (37)
History: 06/2014 - 05/2015

<table>
<thead>
<tr>
<th>Analysis Type</th>
<th>Scheme/Analysis Class</th>
<th>Rule / Pattern</th>
<th>Scored Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheme Analysis - Professional</td>
<td>EM Procedures</td>
<td>Excessive average complex E&amp;M's per day</td>
<td>2.06</td>
</tr>
</tbody>
</table>

Provider 1720042252 FALASCO NORBERT M
Statistical Results:
Rules:
1. Rule EXCESSIVE AVERAGE COMPLEX E&M'S PER DAY revealed the provider billed 352 complex E&M's for 94 days (3.74 complex E&M's per day) resulting in a paid amount of $18,198.

STARSSolutions – Submission Analysis Example

Sentinel Provider ID: 1023373578
Sentinel Name: DIT COACHING SERVICES INC
Specialty: TARGETED CASE MANAGEMENT (TCM)
Sentinel Specialty: Licensed clinical social worker (80)
Rule Analysis Period: Current: 04/2014 - 09/2015
History: 04/2014 - 03/2015

<table>
<thead>
<tr>
<th>Analysis Type</th>
<th>Scheme/Analysis Class</th>
<th>Rule / Pattern</th>
<th>Scored Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Analysis - Professional</td>
<td>Unusual Coding Practice</td>
<td>Excessive billing of same diag and proc</td>
<td>2.90</td>
</tr>
</tbody>
</table>

Provider 1023373578 DIT COACHING SERVICES INC
Statistical Results:
Rules:
Patterns 1. Pattern EXCESSIVE BILLING OF SAME DIAGNOSIS AND PROCEDURE showed the provider billed 1,095 claim lines with 18 distinct diagnosis and procedure code combinations.
STARSSolutions – Example Scheme Analysis

- Sentinel Provider ID: 1205183605
- Sentinel Name: FALCK SE CORP D B A AMERICAN A
- Specialty: Not available (N/A)
- Sentinel Specialty: Specialty group unknown (GSNP)
- History: 06/2014 - 09/2015
- Tax ID: DEA Number:
- License Number:
- Address: PO BOX 538598, ATLANTA, GA 30353
- Region: Georgia (GA)

| Duplicates Analysis | Scheme Analysis | Submission Analysis | Case Number: Investigator: Status: Recoveries: Comments: |
|---------------------|-----------------|---------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Total Score         | 0.13            | 4.99                | 0.00            |                 |                 |                 |                 |
| Claims              | 3               | 971                 | 0               |                 |                 |                 |                 |
| Claim Lines         | 4               | 979                 | 0               |                 |                 |                 |                 |
| Patient Count       | 3               | 500                 | 0               |                 |                 |                 |                 |
| Submitted Amount    | $1,150          | $221,440            | $0              |                 |                 |                 |                 |
| Allowed Amount      | $794            | $286,604            | $0              |                 |                 |                 |                 |
| Denied Amount       | $356            | $92,836             | $0              |                 |                 |                 |                 |
| Paid Amount         | $659            | $87,161             | $0              |                 |                 |                 |                 |

HFPP

- In July 2012, the Secretary of HHS and the Attorney General announced a historic partnership to exchange facts and information between the public and private sectors in order to detect and prevent health care fraud.
- The Healthcare Fraud Prevention Partnership (HFPP) currently has 45 partner organizations from the public and private sectors, law enforcement and associations.
- In 2013 and 2014, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions, including payment suspensions, system edits and revocation of Medicare billing privileges.
Example of a SIU Workflow – Varies Based on State Regulations

Regulatory Challenges

- Approval to refer
- Approval to pursue o/p
- Approval to recover
- Timing for each of above
- Limited ability to show ROI if can’t pursue
- Law Enforcement interaction
- Compliance=FWA/SIU=Program Integrity
- Meetings- in-person vs. phone; level of detail; transitioning to more data sharing;
  - State (all MCOs; MCO-specific)
  - MFCU
  - Federal Task force meetings
  - Bring Something to the Table
Examples of Contract Language

- Statutory language requiring MCOs to report suspected fraud and abuse within 15 calendar days of discovery
- Requirements for specific, designated staff as well as general adequacy requirements
- Contract language requires the MCO’s to submit to a NOI if they suspect fraud or abuse
- Contract language requires the MCO to report recoveries to a monthly basis and quarterly
- Statutory and contract language requiring quarterly and annual activity reports
- Liquidated damages

Regulatory Reporting

- Externally
  - Timing: Monthly, Quarterly, Annually
  - Recoveries/Cost Avoidance
  - Suspensions
  - Providers Terminated
  - Exclusions/Sanctions Checks
  - Actual vs Tips
  - Summary
  - Audits Performed
  - Referrals Made
  - Overpayments Identified
  - Overpayments Recovered
  - New PI Actions
  - List of Involuntary Terminations
  - List of Recipients Referred to OIG

- RFIs
Enforcement Focus: Integrity of Data Submissions

- Medicare Advantage health plans and Medicaid managed care programs must routinely submit data to the government. Some of the data submissions can impact the amount of premium payments the government pays the plans.

- Government auditors are becoming more sophisticated in their ability to detect inaccurate data submissions.

- In its 2016 Mid-Year Work Plan Report*, the HHS-OIG indicates that it is reviewing CMS’s oversight of data integrity for Medicare Advantage plans’ encounter data submissions and is reviewing the sufficiency of documentation submitted by Medicare Advantage plans to support risk adjustment diagnoses.


Enforcement Focus: Integrity of Data Submissions, cont.

  - CMS calculates the payment for Medicare Advantage enrollees based in part on various “risk adjustment data” relating to each enrollee’s health status and other demographic profile information. Some plans conduct record reviews retrospectively to determine whether the risk adjustment data previously filed with CMS is accurate.
  - The federal regulations require Medicare Advantage organizations must certify that the risk adjustment data they submit are accurate, complete and truthful.
  - Here, Relator alleged that certain Medicare Advantage plans designed their retrospective member records intentionally to identify only opportunities for payment increases rather than decreases. How did they allegedly do that?
Enforcement Focus: Integrity of Data Submissions, cont.

- They allegedly retained coding companies or purchased specialized software to perform retrospective reviews of the medical charts of tens of thousands of their patients with severe illnesses but “concealed from the coders the diagnosis codes that had been previously submitted to the Government.” Consequently, “the results of the coders’ reviews did not identify the diagnosis codes unsupported by proper documentation of the reviewed medical charts that had been previously submitted to the Government.”
- One plan allegedly instructed its medical providers to review the medical charts of selected patients to determine whether those charts supported specific diagnoses that had not previously been reported to CMS. The medical providers reported the additional diagnosis codes supported by the records “but made no attempt to determine or report those previously reported diagnosis codes that were unsupported by properly documented medical charts that were reviewed.”
- The plans allegedly used a template to report the results of their retrospective reviews to CMS that allowed coders to enter any additional diagnosis codes identified by the reviews but “did not permit the entry of information indicating what previously submitted [diagnosis] codes should be withdrawn.”
- Several plans allegedly “had RADV audit error rates well in excess of 20%, reflecting that more than 20% of [their] diagnosis codes submitted to CMS were not supported by properly documented medical charts.” Relator alleges the over-reporting error rate found in these audits of representative medical records placed the defendants on notice that the risk adjustment data they more broadly submitted to CMS also contained significant over-reporting errors.

Enforcement Focus: Integrity of Data Submissions, cont.

- After the District Court dismissed his Fourth Amended Complaint with prejudice, the 9th Circuit revived it by holding that:
  - “[W]hen, as alleged here, Medicare Advantage organizations design retrospective reviews of enrollees’ medical records deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness and truthfulness of the data submitted to CMS. This is especially true, when, as alleged here, they were on notice of erroneously reported diagnosis codes.”
- The 9th Circuit found that at least some of the plans were “on notice” of erroneously reported codes by virtue of certain RADV audits with error rates of 20 percent or more.
Enforcement Focus: Integrity of Data Submissions, cont.

- The 9th Circuit distinguished the allegations here from a situation involving a health plan that “passively forwarded to CMS unsupported diagnosis codes they received from their medical providers. That type of conduct would not necessarily result in false … certifications.”
  - The 9th Circuit also pointed out that in a 2000 preamble, CMS stated that MA plans “cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS and the Department of Justice] believe is reasonable to enforce. Simple mistakes will not result in sanctions.”
  - However, the 9th Circuit believed that the allegations here amount to more than “simple mistakes” and instead to “affirmative steps to generate and report skewed data.”
- “If Medicare Advantage organizations acquire the codes identified by retrospective coders, compare them to the codes previously submitted to the CMS, identifying both under- and over-reporting errors, but withhold information about the over-reporting errors from CMS, this would result in a false certification.”

Examples of Referral Packets

Completed Referral Packet submitted should contain the following:
- Identifying Information for Provider, including name, NPI and other known ID #s
- Contract(s) with Health Plan
- Credentialing Information
- Disclosure(s)
- Provider Education; including that specific to activity under review
- Fee Schedule (in Excel format)
- Audits/Communication
- Information on Pre-pay; including Reason(s), Status and History
- Health Plan’s Policy on ________
- Provider participation history & status (MS Word or PDF format)
- Records reviewed
- MCE Coders Report
- Other pertinent Information or data
** Varies by State
SIU Remedial Action Taken

• Once an investigation is completed, the resolution of the case may result in the allegation being unfounded

• Cases that are founded may result in one or more of the following:
  • Provider / Member education
  • Payment suspension
  • Overpayment
  • Referral to government entities
  • Provider / Member termination
  • Referral to member pharmacy lock-in program
  • Settlement or litigation

Other Overpayment Activities

• Other MCO potential overpayments may be attributable to:
  • Retroactive member termination
  • Inappropriate coding
  • Payment duplication
  • Payment for unauthorized services

• Scope / time limitations of recovery efforts
  • Professional Claims (CMS-1500): 12 months from DOS
  • Institutional Claims (UB-04): 30 months from DOS
    • Exception for retrospective disenrollment, where institutional claims are also limited to 12 months from DOS
Tracking Success

• $ Recoveries-Identified vs Recovered
• In house
  – Who records recoveries?
  – Regulatory requirements tied to encounters
• $ Recoveries via External Stakeholders (OIG, State; MFCU, etc…)
• $ Saved/Cost Avoidance
  – What to track
  – How & for how long (12 mo. Vs. perpetuity)
  – Who will track; validation
  – When to track
• Pre-Pay Savings (FWA; Operational Savings)
• Other value
  – Meetings
  – Reports
  – Surveys/Audits

Keys

• Transparency
• Provide expectations; clarify roles
• Solid Relationships
• Communicate, communicate (joint assistance-MFCU)
• Document, document
• Collaborate w/key partners
  – Internally (i.e. provider relations)
  – Externally (i.e. Other SIUs)
• Data-Integrity of data
• No surprises
• Reevaluate/Assess-outside firms review
• ROI $ saved per $ spent
Wrap Up/Questions

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