Current Regulatory Environment

Current Regulatory Landscape
Health Care Fraud and Abuse

Financial accomplishments

In FY 17, the Federal Government won or negotiated over $2.4 billion in judgments and settlements, and attained additional administrative impositions in health care fraud cases and proceedings.

Healthcare fraud-fighting program accomplishments in FY 2017:

• $2.6 billion from judgments and settlements last year, a significant decline from the previous year.
• Of that total, $1.4 billion was paid back to the Medicare Trust Funds and $466.7 million in federal Medicaid money transferred back to the U.S. Treasury.
• The recovered amount is down nearly 21% from last year.
• The return on investment (ROI) for the HCFAC program over the last three years (2015-2017) is $4.20 returned for every $1.00 expended.

Federal Enforcement Initiatives

Medicare questionable claims and payments

- Medicare managers paid billions of dollars for unlawful services beneficiaries:
  - 2017: $38.3 billion and improper payment rate of 9.5%
  - 2016: $41.1 billion and improper payment rate of 11.0%
  - 2015: $43.3 billion and improper payment rate of 12.1%
- Medicare Part D spending for commonly abused opioids exceeded $4 billion in 2015.
- Spending on compounded topical drugs increased more than 3,400% since 2006.
- OIG’s June 2015 data brief described trends in Part B spending, and identified questionable billing by pharmacies.

Rise in OIG Civil Actions

- Source: Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2017.
OIG’s current view on extrapolation and the “5% rule”

- A 5% error rate—the point at which many providers believe they should extrapolate an overpayment instead of repaying it dollar-for-dollar—has moved to a more subjective judgment under the Medicare 60-day overpayment refund rule.
- The HHS Office of Inspector General sees the shift away from the 5% standard in corporate integrity agreements (CIAs) as a way to give health care organizations more flexibility and align with the 60-day rule.
- The 5% rule has been widely used in internal audits and is considered the only precise statement of when to apply extrapolation.
- Providers now have to exercise judgment and make sure a root cause analysis is performed and documented to support the conclusion when not extrapolating.

Source: Report on Medicare Compliance, Volume 27, Number 13 • April 2, 2018

OMIG 2018-2020 Strategic Plan

**Mission**
To enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

**Vision**
To be the national leader in promoting and protecting the integrity of the Medicaid program.

**Goal 1**
Collaborate with Providers to Enhance Compliance

- Coordinate with partners, including the Office of Health Insurance Premiums, to identify and address fraud, waste, and abuse in the Medicaid program.

**Goal 2**
Coordinate with partners to identify and address fraud, waste, and abuse in the Medicaid program.

- Developing innovative and integrated high-level data on fraudulent and wasteful Medicaid activities.

**Goal 3**
Develop innovative and integrated high-level data on fraudulent and wasteful Medicaid activities.

- Enhancing multidisciplinary activities, including improved data access, storage, and mining.
- Utilizing multidisciplinary fraud detection and investigation teams to improve audit and investigation efforts to deter and detect Medicaid fraud.

**Objectives**
- Promote proactive rather than reactive engagement, and participate in fraud prevention activities.
- Generate policy based on prevention efforts.

**Source:** 2018-2019 OMIG Work Plan
OMIG Compliance Activities

Effective compliance programs create a control structure to reduce the potential for fraud, waste, and abuse through self-correction and/or self-reporting of errors by providers.

<table>
<thead>
<tr>
<th>Collaboration with providers to enhance compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMIG will continue to maintain a dedicated telephone line and email address to respond to and address questions related to the implementation and operation of Medicaid provider compliance programs, required by Social Services Law (SSL) § 360-d and 18 New York Codes, Rules and Regulations (NYCRR) Part 521.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OMIG Compliance Program General Guidance and Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMIG will continue to update and publish procedures and forms to assist providers in meeting compliance obligations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OMIG Compliance Program Certification Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers subject to the mandatory compliance program obligations are required to complete an annual certification on OMIG’s website. Providers will be asked to verify compliance with the program.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OMIG Compliance Program Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMIG will conduct compliance program reviews of providers and Managed Care Organizations (MCOs) to assess whether a Medicaid provider’s compliance program is implemented and operating as required by SSL § 360-d and NYCRR Part 521 and issue citations as needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corporate Integrity Agreement Monitoring and Enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMIG will continue to implement, monitor, and enforce corporate integrity agreements (CIA) when terminating or excluding a provider found to have committed fraud, waste, or abuse would have significant impact on recipient access to care.</td>
</tr>
</tbody>
</table>

OMIG

OMIG’s compliance activities are centered on several priority areas: fighting prescription drug and opioid abuse; home health and community-based care; long-term care; transportation; and managed care.

### Omni Presentations

**Combating Prescription Drug and Opioid Abuse**
- Prescription Monitoring
- Residential Provider Investigations
- Collaboration with providers

**Long-Term Care Services**
- Managed Long-Term Care
- Social Worker Case Management
- Partial Delegation
- Enrollment & Eligibility

**Medicaid Managed Care**
- Collaborative Provider Support and Policy Development
- Provider Compliance Project Teams
- Network Provider Review Project Teams
- Pharmacy Review Project Teams

Ongoing Program Integrity Activities

OMIG continues to work with UBIS and the New York City Human Resources Administration (HRA) to conduct reviews of pharmacy, durable medical equipment, transportation agreements, home and community-based care, and assisted living programs. In addition, OMIG will continue to support initiatives to reduce improper payments for all providers in the Medicaid program. OMIG will also conduct investigations related to potential fraud, waste, and abuse of program funds.

### OMIG Investigations

- Prescription Monitoring
- Residential Provider Investigations
- Collaboration with providers

### Long-Term Care Services

- Managed Long-Term Care
- Social Worker Case Management
- Partial Delegation
- Enrollment & Eligibility

### Medicaid Managed Care

- Collaborative Provider Support and Policy Development
- Provider Compliance Project Teams
- Network Provider Review Project Teams
- Pharmacy Review Project Teams

### Other ongoing activities

- Investigations
- Self-Correction
- Transportation
Data analytic activities to detect fraudulent or wasteful activities

Data Review Project Teams
- Ensure OMIG has reliable and usable data from a wide variety of sources & promote transparency, stakeholder communication, & shared decision-making

Innovative Analytics
- OMIG and DOH will be partnering with a data analytics firm to recover erroneous payments made on behalf of incarcerated and/or deceased recipients.

Recovery Audit Contractor (RAC)
- OMIG will continue to collaborate and coordinate recovery initiatives with its RAC, Health Management Systems Inc. (HMS).

Encounter Analysis
- Analyze and evaluate the integrity of encounter data to evaluate the consistency and completeness of MCO encounter reporting.

Innovative Analytics
- OMIG and DOH will be partnering with a data analytics firm to recover erroneous payments made on behalf of incarcerated and/or deceased recipients.

System Match Recovery
- Use analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claims.

Unified Program Integrity Contract (UPIC)
- OMIG will continue its collaboration with Safeguard Services (SGS) under CMS’s Unified Program Integrity Contract (UPIC).

Medicare Home Health Maximizer
- Continue to work collaboratively with its contractor, the University of Massachusetts Medical School (UMass), to maximize Medicare coverage for dual-eligible Medicare/Medicaid recipients.

Third Party Liability (TPL) Match and Recovery Services
- OMIG’s contractor, HMS, will continue to conduct pre-payment insurance verification to identify and utilize third-party coverage.

Highlights of the 2018 OIG Work Plan and Recent Reports

OIG Work Plan: Recently added items

January
- Hospitals billing for severe malnutrition on Medicare claims
- OIG Toolkit to Identify Patients at Risk of Opioid Misuse
- Potential Abuse and Neglect of Medicare Beneficiaries
- Questionable Billing for Off-the-Shelf Orthotic Devices
- Financial impact of health risk assessments and chart reviews on risk scores in Medicare Advantage

February
- Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices
- Review of Statistical Methods Within the Medicare Fee-For-Service Administrative Appeal Process
- State Medicaid Fraud Control Units FY 2017 Annual Report

March
- Data Brief: Opioid Use in Medicare Part D
OIG Medicare Compliance Reviews

In recent reports from January and February, the following audit areas became the focus of three Medicare compliance reviews:

- Incorrect DRG or Discharge Status
- Inpatient Medical Necessity
- Medical Device Credits
- IP Rehab (IRF)

Other audit areas included:
- Outpatient claims
- Same day readmissions
- Claims paid in excess of charges
- Outpatient claims/Modifier 59

*Circle sizes correlate with overpayment amounts based on errors

Compliance Risk Areas

Where should you look to identify risks?

- OIG Medicare Reviews
- Corporate Integrity Agreements (CIA)
- Center for Medicare and Medicaid Services (CMS)
- RAC Focus Areas
- Enforcement
- Phase II
- HIPAA audits
- CAPs
- OCR
- Medicare compliance reviews and fraud alerts
- Center for Medicare and Medicaid Services (CMS)
- Quarterly bulletins
- Open door forums
Medicare RACs
Recent CMS approved audit topics
Performant Recovery, Inc. – Region 1

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date posted to Performant’s website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Pacemaker Review*</td>
<td>02/15/2018</td>
</tr>
<tr>
<td>Evaluation and Management (SNF) Same Day as Dialysis</td>
<td>01/16/2018</td>
</tr>
<tr>
<td>Initial Physician Pre-Admission (IPPA) or Acute Care Admission (ACA)</td>
<td>01/15/2018</td>
</tr>
<tr>
<td>CMS Codes billed within a Procedure Code with a 10 Day Global Period (other than appendectomy)</td>
<td>01/15/2018</td>
</tr>
<tr>
<td>CMS Codes billed within a Procedure Code with a 30 Day Global Period (other than appendectomy)</td>
<td>01/15/2018</td>
</tr>
<tr>
<td>Drugs and Biologics Overutilization or Insufficient Drug Utilization</td>
<td>01/15/2018</td>
</tr>
<tr>
<td>CMS Codes billed within a Procedure Code with a 0 Day Global Period (endoscopies or some)</td>
<td>01/10/2018</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.

Medicare RACs
Recent CMS approved audit topics
Performant Recovery, Inc. – Region 5

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date posted to Performant’s website</th>
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</thead>
<tbody>
<tr>
<td>Negative Pressure Wound Therapy Pumps (NPWT)*</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>Hypertensive Subjects to CMS Requirements as of an earlier January 1, 2016</td>
<td>03/01/2018</td>
</tr>
<tr>
<td>Home Health Services: Documentation and Medical Necessity*</td>
<td>03/01/2018</td>
</tr>
<tr>
<td>Respiratory Assist Devices*</td>
<td>01/15/2017</td>
</tr>
<tr>
<td>NP Devices for the Treatment of Obstructive Sleep Apnea*</td>
<td>04/18/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.
Medicare RACs
Recent CMS approved audit topics
Cotiviti, LLC – Regions 2 and 3

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date approved</th>
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</thead>
<tbody>
<tr>
<td>Complex Cardiac Pacemaker Review*</td>
<td>02/15/2018</td>
</tr>
<tr>
<td>Evaluation and Management (E/M) Same Day as Dialysis</td>
<td>01/11/2018</td>
</tr>
<tr>
<td>Annual Wellness Visits (AWV) billed within 12 months of (IPPE) or (AWV)</td>
<td>01/09/2018</td>
</tr>
<tr>
<td>Excessive or Insufficient Drugs and Biological Units Billed*</td>
<td>12/21/2017</td>
</tr>
<tr>
<td>E&amp;M Codes billed within a Procedure Code with a 10 Day Global Period (other minor procedures)</td>
<td>12/12/2017</td>
</tr>
<tr>
<td>E&amp;M Codes billed within a Procedure Code with a 90 Day Global Period (major surgeries)</td>
<td>12/12/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.

Source: http://www.cotiviti.com/healthcare/who-we-serve/cms-approved-issues

Medicare RACs
Recent CMS approved audit topics
HMS Federal Solutions – Region 4

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date posted to HMS’ website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Pacemakers*</td>
<td>02/15/2018</td>
</tr>
<tr>
<td>Global Days 90*</td>
<td>02/15/2018</td>
</tr>
<tr>
<td>Evaluation and Management (E/M) Same Day as Dialysis</td>
<td>01/12/2018</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV) billed within 12 months of the Initial Preventative Physical Exam (IPPE)</td>
<td>01/12/2018</td>
</tr>
<tr>
<td>Excessive or Insufficient Drugs and Biological Units Billed*</td>
<td>12/29/2017</td>
</tr>
<tr>
<td>E&amp;M Codes billed within a Procedure Code with 10 Day Global Period (other minor procedures)*</td>
<td>12/13/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.

Source: https://racinfo.hms.com/Public1/NewIssues.aspx

CMS outreach and education
Medicare quarterly provider compliance newsletter – January 2018

- Finding: Insufficient Documentation Causes Most Improper Payments
- Advance Care Planning (ACP) is a face-to-face service that includes counseling and discussion of an advance directive.
- A special study of claims with code for ACP billed with Current Procedural Terminology (CPT) code 99497 (ACP by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) submitted from April through June 2016.
- Many ACP special study claims with insufficient documentation lacked clinical documentation to support that a face-to-face service, discussing ACP, was performed, and/or clinical documentation of the time spent discussing the ACP.


Proper use of modifier 59
- Finding: There are still many instances where modifier 59 is used inappropriately.
- Use of modifier 59: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not routinely reported together, but are appropriate under the circumstances.
- Per CMS, modifier 59 and other National Correct Coding Initiative (NCCI)-associated modifiers should NOT be used to bypass a Procedure-to-Procedure (PTP) edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.
- The function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those situations where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used inappropriately.

On January 17, 2018, Gary Cantrell from the OIG’s Office of Investigations provided testimony before the House of Representatives Committee on Ways and Means, Subcommittee on Oversight.

**Key Statistics**
- More than 50,000 Americans died from drug overdoses in 2015, of which 63% reportedly involved opioids.
- According to CDC, approximately 3 out of 4 new heroin users report having abused prescription opioids prior to using heroin.
- Prescription drug diversion is a serious component of this epidemic.

**OIG’s Opioid Fraud Enforcement Efforts**
- July 2017 OIG data brief, *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*:
  - 1 in 3 Part D beneficiaries received opioids in 2016 (14.4 M beneficiaries).
  - Approximately 500,000 beneficiaries received high amounts of opioids (by looking at morphine equivalent doses received).
  - Beneficiaries with cancer diagnosis and those in hospice were excluded from the analysis.
  - OIG identified approximately 90,000 beneficiaries at serious risk of opioid misuse or overdose via 1) receiving extreme amounts or 2) doctor shopping and also identified 400 providers with questionable opioid prescribing patterns.

**Curbing the Opioid Epidemic – OIG Efforts Currently Underway**
- OIG currently has seven audits or evaluations underway which address the following issues:
  - Questionable prescribing patterns in Medicaid
  - Medicaid program integrity controls
  - CDC’s oversight of grants to support programs to monitor prescription drugs
  - The FDA’s oversight of opioid prescribing through its risk management programs
  - The Substance Abuse and Mental Health Services Administrator’s oversight of opioid treatment program grants
  - Beneficiary access to buprenorphine medication-assisted treatment
  - Opioid prescribing practices in the Indian Health Services.

**Inpatient Psychiatric Facilities – Medicare Requirements Overview**
- Recent CMS approved audit topic for Medicare RACs.
- As of September 8, 2017, one of the recent CMS approved audit topics includes Inpatient Psychiatric Facility Services - Complex Review. Inpatient hospital services furnished in an inpatient psychiatric facility will be reviewed to assess whether services were medically reasonable and necessary. Further, Inpatient Psychiatric Facility Outlier Payments were a new addition to the 2017 OIG Workplan.

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**Source:** [https://oig.hhs.gov/testimony/docs/2018/cantrell-testimony-01172018.pdf](https://oig.hhs.gov/testimony/docs/2018/cantrell-testimony-01172018.pdf)
Inpatient psychiatric facilities – Medicare conditions of payment

Requirements:
The inpatient admission order must state that the beneficiary should be formally admitted for hospital inpatient care, and must be furnished at or before the time of the inpatient admission by a physician or other qualified practitioner.*

Timing and Signature Requirement:
Verbal/Telephone admission order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner prior to discharge.

* A “qualified practitioner” is someone who is licensed; has admitting privileges at the hospital as permitted by State law; is knowledgeable about the patient’s hospital course, medical plan of care, and current condition; and acts in accordance with scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

Inpatient psychiatric facilities – Medicare requirements overview (cont’d)

Why are inpatient psychiatry requirements different from general inpatient requirements?

The purpose of Inpatient Psychiatric Facility (IPF) Medicare Requirements is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage.

IPFs are certified under Medicare as inpatient psychiatric hospitals and their documentation/content requirements are different from general inpatient documentation/content requirements because the care furnished in inpatient psychiatric facilities is often purely custodial and thus not covered under Medicare.

For purposes of payment for IPF under Medicare Part A, required conditions of payment requirements (including admission order, certification, recertification) where required) must be met.

Medicare Part A pays for inpatient services in an IPF only if a physician (not a mid-level practitioner) certifies and recertifies the need for services consistent with the Medicare requirements for inpatient services of inpatient psychiatric facilities. Medical record documentation must support the physician’s certification / recertification.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff.

Admission Order Requirements:
The inpatient admission order must state that the beneficiary should be formally admitted for hospital inpatient care, and must be furnished at or before the time of the inpatient admission by a physician or other qualified practitioner.*

Timing and Signature Requirement:
Verbal/Telephone admission order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner prior to discharge.

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Speaker contact information

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