The Intersection of Health Care Fraud and Patient Safety

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January 16, 2018

Overview

- The Wisconsin DHS-OIG Audit Process
- Beneficiary Fraud and Medical Identity Theft
- Examples of OIG's Criminal Fraud Referrals
- The Future of Medicaid Fraud Investigations

What is OIG?

The Office of the Inspector General (OIG) within the Wisconsin Department of Health Services (DHS) has the responsibility to root out fraud, waste, and abuse in state benefits programs.

- Medicaid
- FoodShare
- WIC
- Other DHS-funded programs and services

What is OIG?

OIG is organized into five sections:

- Fraud Investigation, Recovery and Enforcement
  - Beneficiary investigations for violation of program rules in Medicaid and FoodShare
  - WIC retailer audits and investigations
- Internal Audit
  - Conducts internal audits of DHS programs
  - Identifies potential risks
  - Reviews the audited financial reports of DHS grantees

What is OIG?

(continued)

- Medical Audit and Review Section
  - Nurse auditors
  - Audits more clinical in nature
- Program Audit Review Section
  - Auditors
  - Audits more focused on documentation, financial records and program compliance

What is OIG?

(continued)

- Data Analytics Section
  - Provides data analysis and investigative support to other OIG sections
  - Reviews leads generated by and directs the work of data analytics vendor
  - Assists in identifying trends and outliers in benefits areas and provider types

Audit Authority

- OIG has the responsibility to monitor for quality and appropriateness of Medicaid-paid services.
- OIG has been given the authority to audit through the administrative rules that have been promulgated by DHS.

Documentation Counts

DHS may refuse to pay claims and may recover previous payments made on claims where the provider fails or refuses to prepare and maintain records or permit authorized department personnel to have access to records. (Wis. Admin. Code § DHS 106.02)

Who We Audit

- Medical Audit and Review Section (nurse auditors)
  - Physicians
  - Dentists
  - Clinics
  - Personal care agencies
  - Home health agencies
  - Hospice providers
  - Laboratories

Who We Audit

(continued)

- Nurses in independent practice
- Mental health providers
- Services requiring certificate of need (CON)
- Therapy providers
- Physical therapy
- Occupational therapy
- Outliers in the provider's specialty

Who We Audit

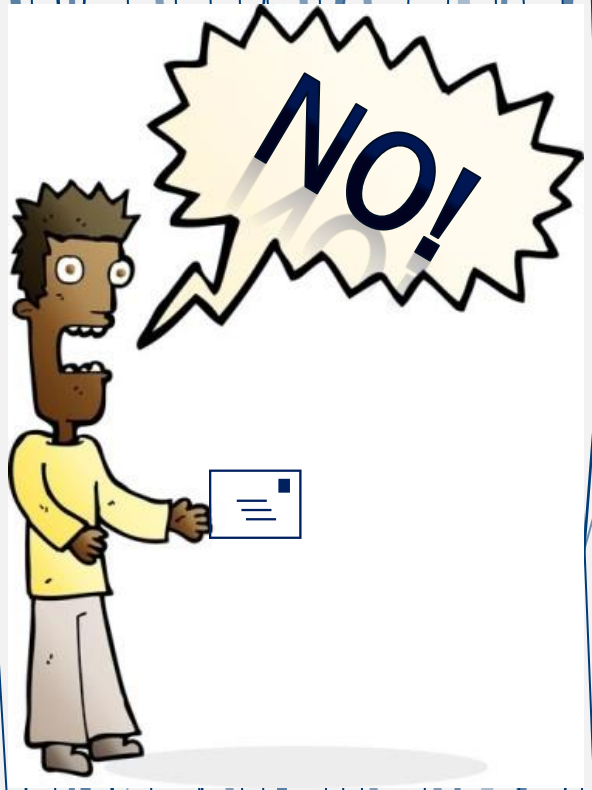
(continued)

- Prenatal Care Coordination
- Pharmacy
- Durable Medical Equipment
- Disposable Medical Supplies
- Laboratories
- Specialized Motor Vehicles
- Electronic Health Record compliance

Who We Audit

- Program Audit and Review Section (Auditors)
  - Medicaid managed care programs
  - Long-term care programs
  - County, community, and tribal mental health support programs
  - Outliers in the provider's specialty

So you got an audit notice.



The DHS-OIG Audit Process

- Notification and Request for Records
  - Can be by mail or in person
  - With or without notice
- Preliminary Findings letter and report
- Rebuttal from provider
- Amended Preliminary Findings or Notice of Intent to Recover
- Appeal Process

You know who, but why?

- Complaints
- Providers with enrollment site visit findings
- Previously audited providers open a new business
  - Employees who are business jumpers
  - Members who flow from one provider to another en masse

You know who, but why?

- Providers in high-risk service areas
  - Home health agencies
  - Medical equipment vendors
  - Personal care agencies
  - Prenatal care coordination
  - Specialized medical vehicle
- Policy compliance monitoring as requested by other DHS Divisions

What do OIG audits find?

- Lack of documentation
  - Were services actually rendered?
  - Upon what was the claim based?
- Incomplete documentation
- Billing in excess
  - In excess of prior authorization
  - In excess of documentation

What do OIG audits find?

- Wrong procedure codes
- Non-covered services
- Incorrect rendering provider listed on claim
- Lack of a physician’s order
- Services not medically necessary
- Upcoding

What do OIG audits find?

- Unbundling of bundled services
- Lack of personnel files or background checks for certain providers
- Billing in excess of units allowed
  - Private duty nursing
  - Personal care

Is this about the money?

- Yes and no
  - Yes, because Medicaid is taxpayer-funded.
  - In State Fiscal Year 2016, Wisconsin Medicaid's budget was $7.7 billion.
  - If just 1 percent of that budget is lost to fraud, waste, or abuse, that's $77 million in lost funds.

Is this about the money?

(continued)

- Bad documentation and bad claims jeopardize patient health and safety.
- Providers who improperly document claims put bad information in the patient's medical record.
- In the era of electronic health records, this bad information might follow a patient forever.

Patient C

- Patient C was a disabled child on Wisconsin Medicaid who required in-home nursing care.
- Patient C was authorized to receive 18 hours of in-home nursing care each day.
  - Two nurses: Nurse A and Nurse B
  - Total cost was more than $200,000 per year

Patient C

- Patient C was totally dependent on his caretakers for food, water, bathing, and daily living.
- Despite having 18 hours of in-home nursing care each day, Patient C was admitted to the hospital for severe dehydration and malnutrition.
- Patient C was unresponsive and placed in critical care.
- Patient C had lost approximately 10 percent of his body mass/weight since a clinic visit four months earlier.

Patient C

- Local law enforcement initiated an investigation.
- Police asked Patient C's sister if she ever saw a nurse with her brother when she went to bed at night or when she woke up in the morning. (No.)
- Police asked Nurse A and Nurse B to describe Patient C's nutrition packs.
- Police asked Nurse A and Nurse B to talk about what type of medications Patient C took and when.

Patient C

- Police notified OIG about the potential Medicaid fraud.
- OIG audited both nurses.
  - Nurse A could provide no documentation.
  - On rebuttal, Nurse B provided documentation of nearly all shifts.
  - Nurse B's documentation for in-home nursing care included shifts that overlapped with Patient C's outpatient care and her other job.

Patient C

- OIG suspended Medicaid payments to Nurse A and Nurse B based on credible allegations of fraud and referred the case to the Wisconsin Department of Justice (DOJ) for a criminal investigation, which is ongoing.
- Patient C died 14 months after the initial incident.

Patient C

What does Patient C's story tell us?

- According to medical records, billing records and payment records, he was receiving skilled nursing care 18 hours each day.
- These allegedly false or fabricated records affected Patient C's continuity of care.
- Stories like Patient C's are why home-based health services are considered at high risk for fraud.

Cute Dog Break

Meesha and Lola

Beneficiary Fraud

There are many types of Medicaid beneficiary fraud:

- Concealing income
- Lying about household composition or address
- Card sharing
- Check splitting
- Medical identity theft

Beneficiary Fraud

Concealing income

- Failing to report the income from a job, business, or self-employment
- Failing to report income of other persons in the household
- Failing to disclose income from annuities or trusts

Beneficiary Fraud

Lying about household composition or address

- Reporting that a spouse or child's parent lives outside the home
- Lying about Wisconsin residency
- Reporting children live in the home when they actually live elsewhere

Beneficiary Fraud

Card sharing

- Allowing a friend or relative to use Medicaid benefits to receive services
- Allowing a provider to bill for services not rendered and splitting the money

Beneficiary Fraud

Check splitting: Working with a home-based provider to receive unnecessary services and splitting the money

- In-home nurses
- Personal care

These arrangements often end with one party reporting fraud against the other

Beneficiary Fraud

Medical identity theft

- Applying for benefits using someone else's personal information
- Stealing someone's Medicaid identification card and using it to receive care
- In collusion with a provider, stealing someone's Medicaid identification and using it to bill Medicaid for services not rendered

Beneficiary Fraud

How does beneficiary fraud jeopardize the Medicaid program and patient safety?

- Beneficiary fraud removes funds from the program that should go to others.
- Card sharing and medical ID theft create false patient records and threaten continuity of care.
  - Appendicitis ruled out for a patient who appears to already have had an appendectomy
  - False positives for potential medication interactions

Criminal Fraud Referrals

- Federal law requires the OIG to refer all “credible allegations” of Medicaid provider fraud to Wisconsin DOJ Medicaid Fraud Control and Elder Abuse Unit. (42 CFR 455.21)
- DOJ accepts or declines the referral.

Criminal Fraud Referrals

- If the referral is accepted, OIG suspends Medicaid payments to the provider.
  - OIG can impose a partial suspension in certain cases.
  - DOJ can request no suspension be imposed in order to conduct investigations without alerting providers.
- DOJ investigates the provider for potential criminal charges or civil litigation.

Criminal Fraud Referrals

- If DOJ closes the investigation with no charges or civil action, the payment suspension is lifted.
- If DOJ obtains evidence for a criminal charge, DOJ attorneys initiate criminal proceedings.

Credible Allegations of Fraud

- A mental health counselor in Wisconsin allegedly billed Medicaid for counseling sessions that were never rendered.
- Travel and financial documentation indicated the provider billed for sessions while traveling throughout the northeastern United States.

Credible Allegations of Fraud

- Investigators interviewed multiple patients who asserted they never saw the counselor, or that the counselor continued to bill for sessions long after they stopped going.

Credible Allegations of Fraud

- Multiple providers have been referred to DOJ for investigation after complaints from members or former employees indicated that they billed for services for dates of service when they were traveling out of the state or out of the country.

Credible Allegations of Fraud

- Facebook posts including geo-tags and time stamps helped bolster the referrals to DOJ.
- While social media posts are not sufficient evidence of fraud alone, DOJ can and will pull travel and financial records to confirm a provider's location of a date of service.

Credible Allegations of Fraud

- After a complaint of billing for services not rendered, OIG audited a physician who used an Electronic Health Record (EHR) system.
- Almost immediately, OIG auditors noted what appeared to be copy and pasted notes for dozens of patients.
  - Pronoun mismatches for patients
  - The same spelling error in the same spot in each patient's chart
  - Same diagnosis, complaint and symptoms for each patient

Credible Allegations of Fraud

- The EHR audit trail indicated the physician copy and pasted all of the patient notes under review over a long holiday weekend (well after the dates of service), appearing to take breaks to eat and sleep.

Credible Allegations of Fraud

Time-traveling and teleporting providers

- On several occasions, OIG has referred providers to DOJ who purportedly rendered more services than were possible in a single day.
  - A physician billed Medicaid fee-for-service and Medicaid HMOs simultaneously for office visits that, when totaled, equaled more than 24 hours each day.
  - The same physician also billed for services at another location miles away during the time the office visits supposedly occurred.

Credible Allegations of Fraud

- During a three-month period, a personal care worker billed for an average of 20 hours each day, every single day of the month.
- The worker billed for more than 24 hours of services on several days during the same period, all while working a second job.

Cute Dog Break

Meesha and Lola

The Future of Medicaid Fraud Investigations

- The future of Medicaid fraud investigations is data driven.
- Pay and chase strategies have been successful, but they are inefficient and rely too heavily on complaints

The Future

Preliminary data work

- Outliers for certain billing codes
- Outliers for certain provider types
- Inpatient and outpatient service overlap
- For beneficiaries, combine data sources for persons likely to live out of state

The Future

(continued)

- Beneficiary matches to jails and prisons
- Beneficiary and provider address overlap
- Trend analysis
- Date of death audits

The Future

Data work under development

- Relationship mapping
  - Provider to provider
  - Provider to beneficiary
  - Provider to criminal enterprises
- Suspicious addresses
  - Multiple providers at one address
  - Multiple recipients at same address

The Future

(continued)

- Social relationship analysis
  - High number of opiate prescriptions to multiple members of same family at same address
  - High number of related beneficiaries visiting out-of-state providers
- Fraud scoring

The Future

- Leads developed using data analysis will be thoroughly investigated, but algorithms alone won't be used to find fraud, waste and abuse.
- Strong leads could lead to prepayment review, provider education or referral for investigation.
- OIG is committed to increased cooperation with Medicaid's managed care companies.

What does it all mean?

- OIG exists to root out fraud, waste, and abuse in the Wisconsin Medicaid program.
- Audits are not fun, but they are necessary to ensure program integrity and patient safety.
- We welcome providers to be our partners in this endeavor.

THANK YOU!

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