LESSONS FOR AVOIDING MEDICAID FRAUD, WASTE AND ABUSE:

A PRESENTATION FOR NEW JERSEY DURABLE MEDICAL EQUIPMENT PROVIDERS

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

June 24, 2025

Welcome to the presentation. We will begin momentarily.

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

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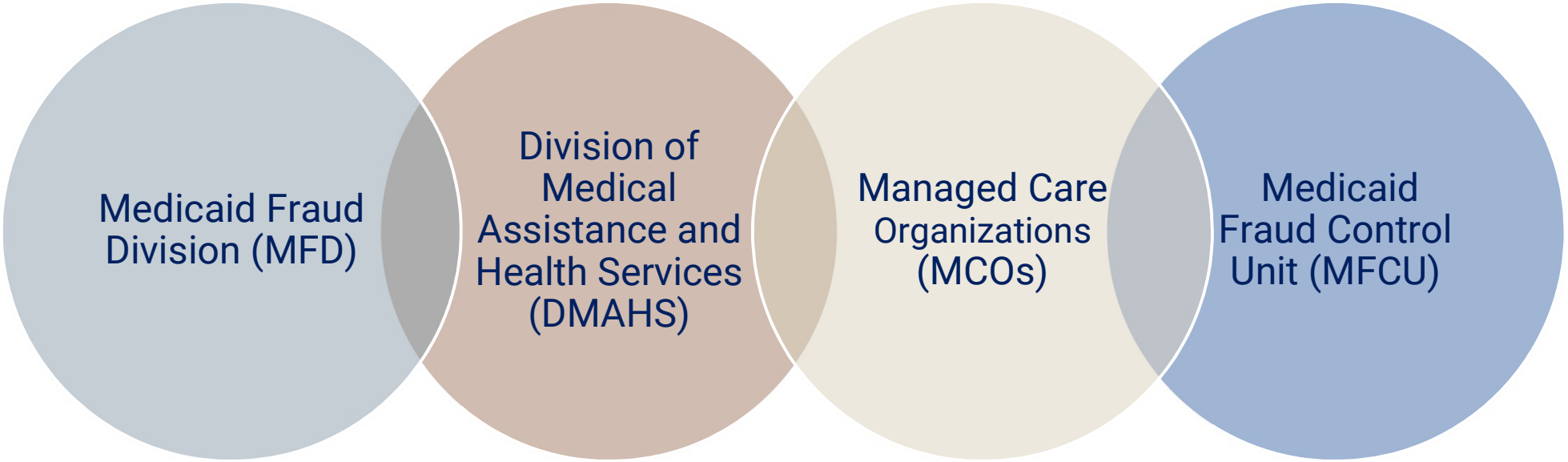
PRESENTED IN PARTNERSHIP BY:



BEFORE WE BEGIN…

THANK YOU

for participating in the

NJ FamilyCare program!

DISCLAIMER

- This presentation is intended for general educational purposes only.
- It does not replace your responsibility to seek professional guidance, observe all laws and regulations that pertain to your practice as a Medicaid provider and exercise sound, independent, professional judgment.

GOALS FOR TODAY: TO HELP YOU BETTER UNDERSTAND

- The Medicaid program regulatory oversight structure and compliance requirements
- Medicaid documentation requirements for payment
- Fraud, waste, and abuse obligations of providers (prevention and reporting)
- Red flag areas and the consequences for non-compliance by providers

QUESTIONS?

Questions?

Enter them in the Q & A

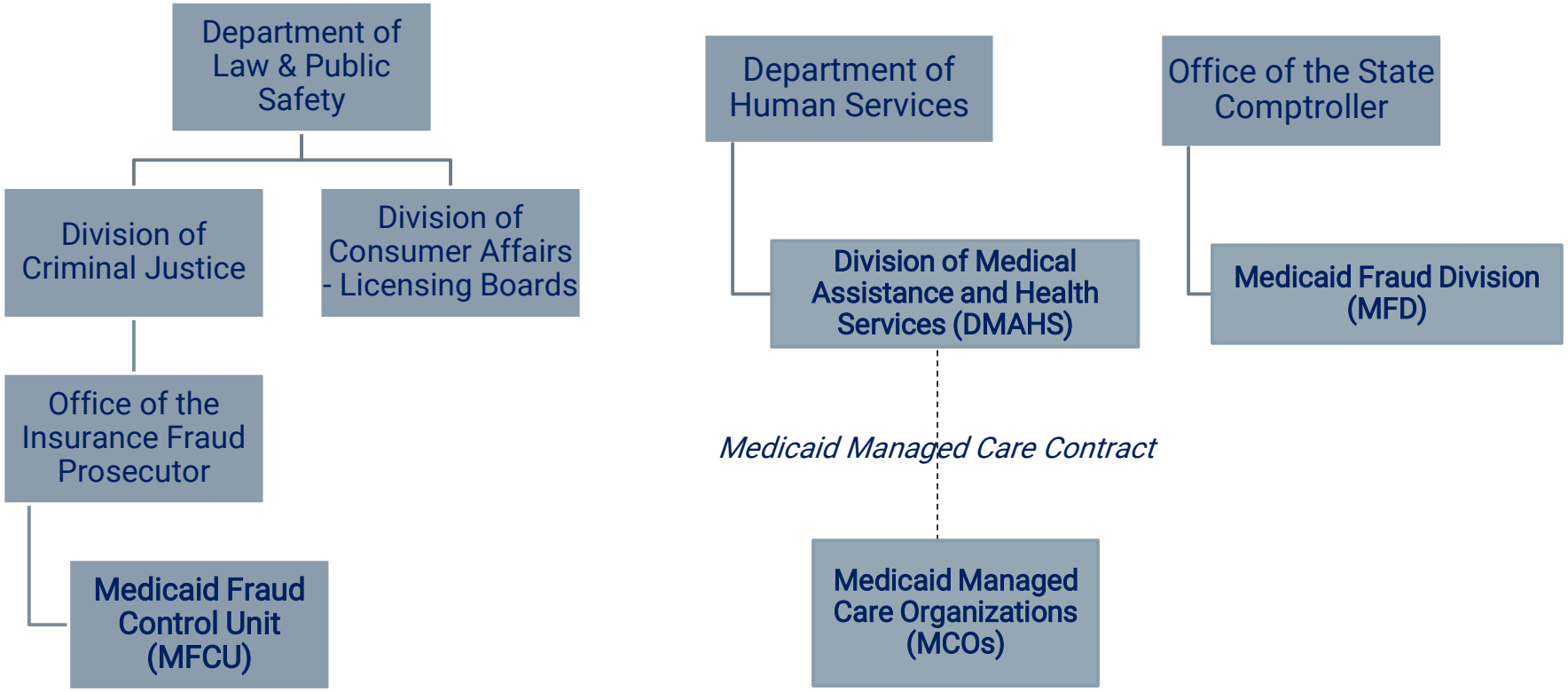
WHAT IS MEDICAID?

- A joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals.
- Medicaid participation is voluntary.
- If you want to participate, you must know, accept and abide by the rules and regulations. Continued participation requires compliance with the regulatory requirements.

MEDICAID (NJ FAMILYCARE)

- Throughout this presentation the words Medicaid and NJ FamilyCare may be used interchangeably.
- NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion, with services provided through the State and the five Medicaid Managed Care Organizations (MCOs).

NEW JERSEY AGENCY ADMINISTRATION AND MEDICAID OVERSIGHT



GUIDING REGULATIONS, AND NEWSLETTERS

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)

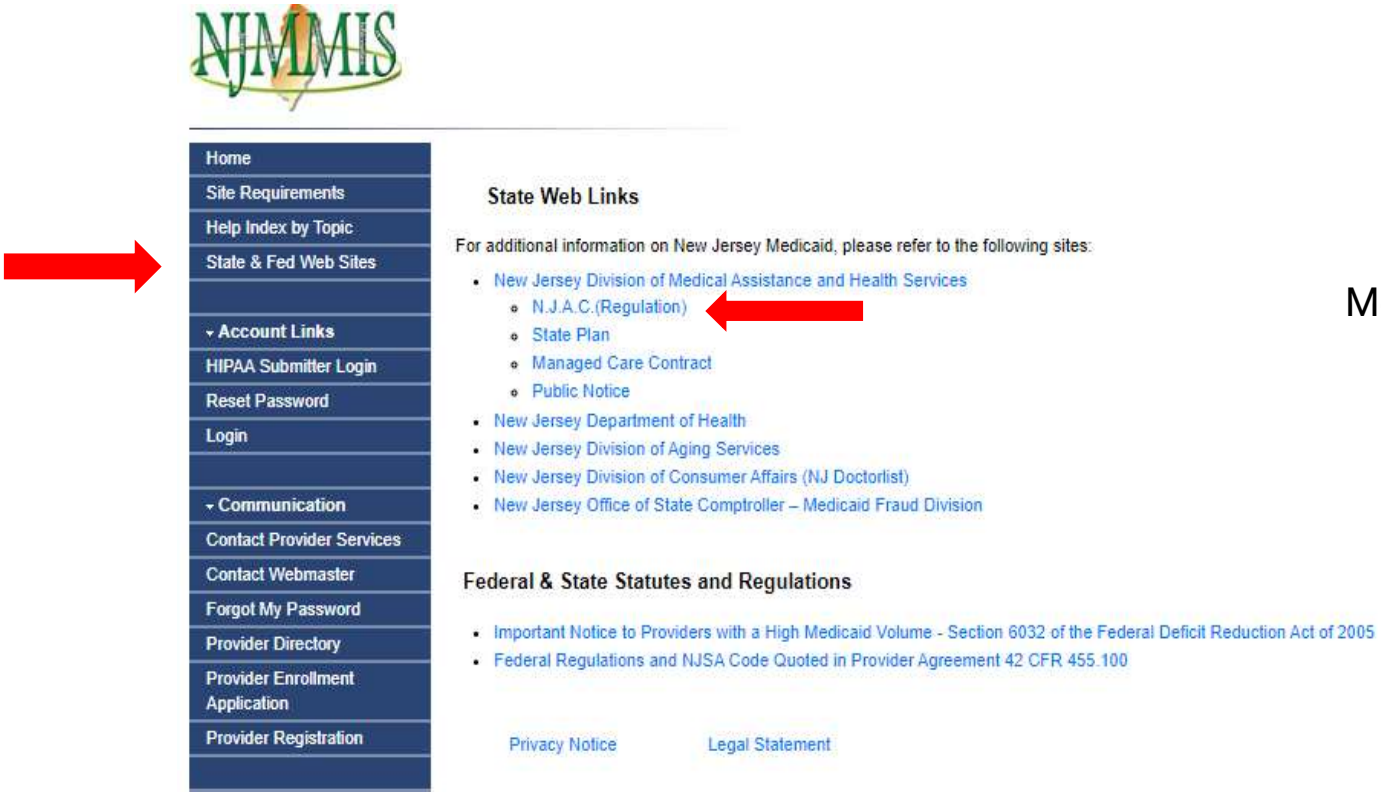
Presented by: Geralyn Molinari, Director, Managed Provider Relations,
Department of Human Services, Division of Medical Assistance and Health Services

DMAHS

- The Division of Medical Assistance and Health Services (DMAHS) is part of the NJ Department of Human Services.
- DMAHS administers the Medicaid program for certain groups of low to moderate income people.

DMAHS REGULATIONS

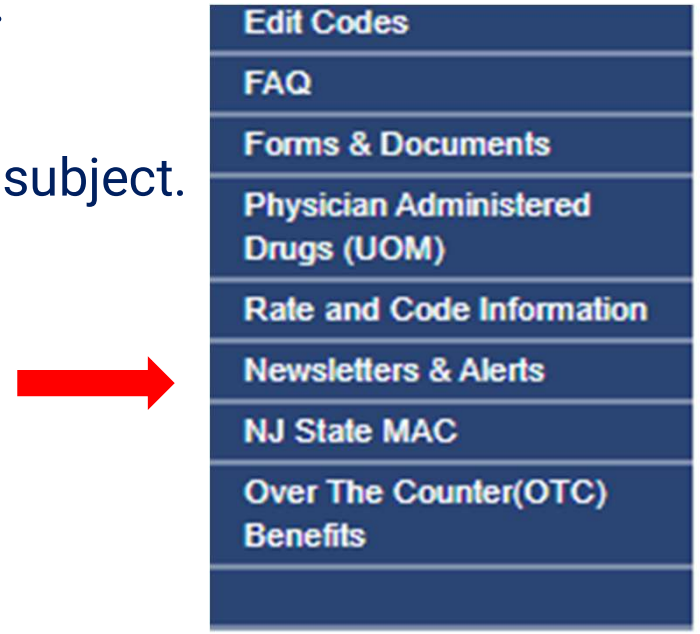
WWW.NJMMIS.COM



N.J.A.C. 10:59
Medical Supplies and Durable Medical Equipment

DMAHS NEWSLETTERS

- Medicaid Newsletters are used to introduce new programs or services, pending regulatory updates or general program guidance.
- Newsletters can be found on www.njmmis.com.
- Newsletters are searchable by provider type and subject.



21ST CENTURY CURES ACT
42 U.S.C. 1396u-2(d)

- The 21st Century Cures Act requires all Fee For Service (FFS) and MCO Enrolled providers to submit a completed 21st Century Cures Act application to Gainwell Technologies.
  - Providers under contract with multiple MCOs are only required to submit a single 21st Century Cures Act application to Gainwell.
- To download, go to:
  - www.njmmis.com
  - Select *Provider Enrollment Applications > 21st Century Cures Act Application*
- Questions can be directed to Gainwell Technologies Provider Enrollment Unit at 609-588-6036 or NJMMISproviderenrollment@gainwelltechnologies.com.

MEDICAID MANAGED CARE CONTRACT

- DMAHS has a contract with the following Medicaid Managed Care Organizations (MCOs):

  - Aetna Better Health of New Jersey
  - Wellpoint (formerly Amerigroup New Jersey, Inc.)
  - Horizon NJ Health
  - UnitedHealthcare Community Plan
  - Fidelis Care (formerly WellCare Health Plans of New Jersey, Inc.)

PROVIDER ENROLLMENT - CMS DESIGNATED HIGH-RISK

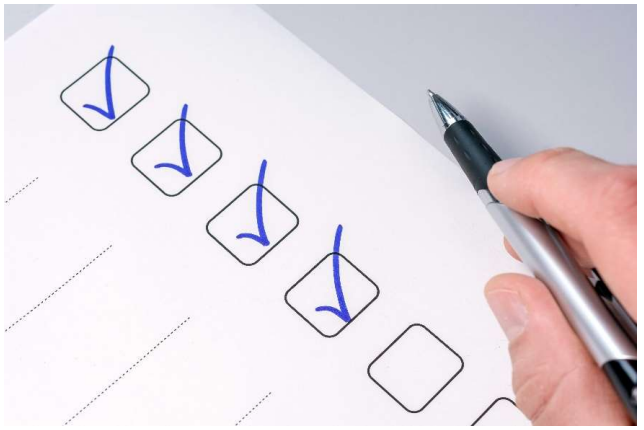
Presented by: Kassandra Phipany, Supervising Investigator, Provider Enrollment
Office of the State Comptroller, Medicaid Fraud Division

WHAT IS CMS HIGH-RISK?

- CMS assigns risk categories to provider types based on factors.
- The category a provider type is assigned impacts the level of scrutiny during enrollment and revalidation.
- CMS rated Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics & Supplies, or DMEPOS – high-risk

PROVIDER ENROLLMENT – WHAT TO EXPECT

- Eligibility determined after a thorough review of the application
- On-site visit
- Federal Background Check through fingerprinting – owners of 5% or more and, if none, managing employees



MCO SPECIFIC REQUIREMENTS FOR PARTICIPATION

Presented by: Angelica Miranda, Senior Manager, Network Management
Aetna Better Health of New Jersey

MCO REQUIREMENTS FOR PARTICIPATION

- Participating with an MCO will allow your group to provide services to eligible NJ Medicaid members enrolled with that plan.
- Two main parts to this process:

Provider Credentialing

Provider Contracting

PROVIDER CREDENTIALING

- Credentialing - the way in which the MCO can verify the provider has all the required documentation to participate.
- It ensures quality, compliance, and accountability.

CREDENTIALING REQUIREMENTS

Credentialing Application

- Detailed application form to collect necessary information

Business License

- Proof of valid and current license

Professional Liability Insurance

- Evidence of liability insurance coverage

W9

- Federal Tax Identification Number and Mailing Address

NJ State Medicaid ID

- Enrolled in 21st Century Cures Act

PROVIDER CONTRACTS

- The contract makes you a participating provider with the MCO, allowing you to provide services to eligible MCO NJ Medicaid members.

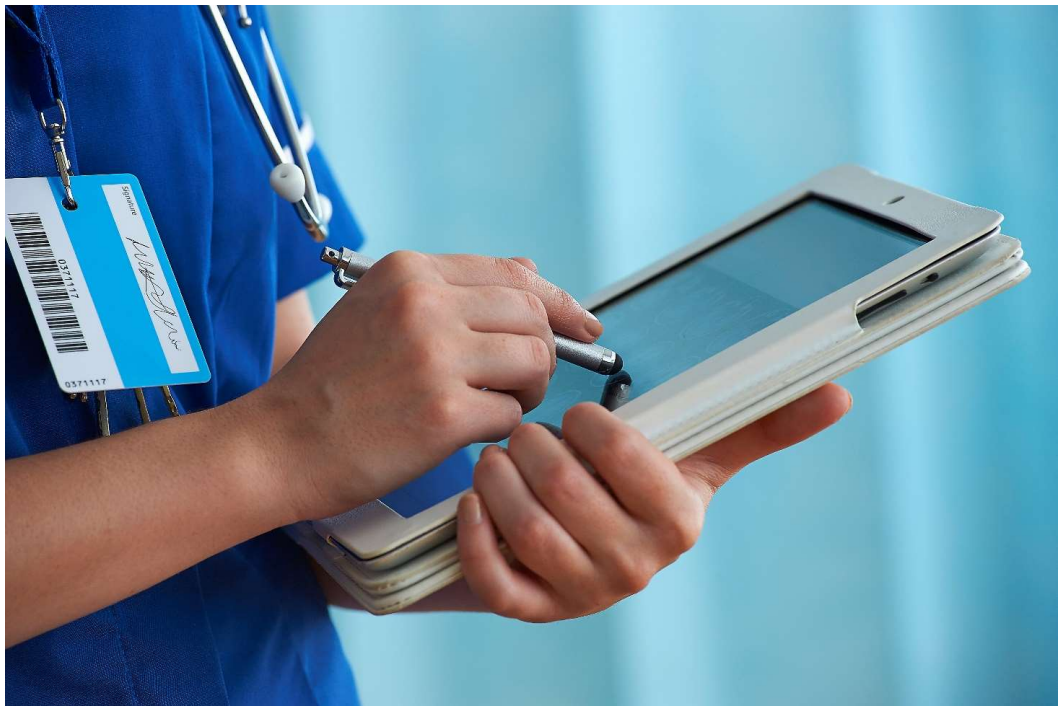
SUBMISSION OF CREDENTIALING PACKAGE

- Once the entire credentialing package (including signed contract) is complete, it is submitted to the MCO Credentialing Department for processing.
- The credentialing process takes approximately 60 to 90 days for completion; consult with the MCO for specific timelines.

MEDICAID REQUIREMENTS FOR PAYMENT
(DOCUMENTATION, BILLING GUIDELINES, AND RECORDS RETENTION)

Presented by: Puneet Kumar, MD, Physician Specialist
Department of Human Services, Division of Medical Assistance and Health Services

DOCUMENTATION



DOCUMENTATION - PRIOR AUTHORIZATION (PA) FEE FOR SERVICE (FFS)

- FFS prior authorization required for:
  - DME - items over $300
  - Supplies – items over $100

- If HCPCS codes require PA - PA shall reflect decisions based on medical necessity and/or purchase/rental options

DOCUMENTATION - PRIOR AUTHORIZATION (PA) FEE FOR SERVICE (FFS)

- When a procedure code requires PA - the PA shall be obtained from the appropriate Medical Assistance Customer Center (MACC) with the exception of the following:
  - Prosthetics and Orthotics (P&O)
  - Specialized wheelchairs or equipment
  - Ventilatory and Intermittent Positive Pressure Machine (IPPM)
  - Hospital beds or pressure reduction mattresses
  - Total Parenteral Nutrition
  - Facility requests (nursing homes and ICF-DD)
  - Augmentative communication systems

MACC Office Locations
Camden County - Camden
Essex County - Newark
Monmouth County - Freehold
Passaic County - Paterson

DOCUMENTATION - PRIOR AUTHORIZATION (PA)
FEE FOR SERVICE (FFS)

Shall be sent to:

Office of the Medical Director
Division of Medical Assistance and Health Services
PO Box 712, Mail Code 25
Trenton NJ 08625-0712
Or
Fax to: 609-588-4614

DOCUMENTATION – PHYSICIAN ORDER (FFS AND MCO)

N.J.A.C. 10:59-1.5

Medical supplies and equipment require a legible, dated prescription or a Certificate of Medical Necessity (CMN) personally signed by the prescribing practitioner.

DOCUMENTATION –PRESCRIPTION - REQUIRED ELEMENTS (FFS AND MCO)

N.J.A.C. 10:59-1.5

Beneficiary's Info

- Name
- Address
- Medicaid/NJ FamilyCare eligibility identification number

Description of supplies/equipment prescribed

- Item Type and Style specified
- Must be specific
  - "wheelchair" or "patient needs wheelchair" is insufficient; must describe the type and style of wheelchair.

Length of time required

Diagnosis and summary of the patient's physical condition to support item(s) prescribed

Prescriber's Info

- Name
- Address
- Signature

Other information may be required for specific items and services – refer to 10:59-1.5 for more info

DOCUMENTATION - PRIOR AUTHORIZATION (PA) MCO

- MCO authorization - obtained through MCO-specific form and/or provider portal
- MCO PA requirements can vary due to:
  - Item
  - Dollar amount of item
- Links to MCO PA forms and provider manuals - on the following slide

MCO PROVIDER MANUALS AND PA FORMS

MCO Name	Provider Manuals	DME PA Forms
Aetna Better Health of New Jersey	Aetna PM	Aetna PA
Fidelis Care	Fidelis Care PM	Fidelis Care PA *Select DME Authorization request*
Horizon NJ Health	Horizon PM	Horizon PA* *PA is done via the Availity system*
UnitedHealthcare Community Plan	United PM	United PA* **PA is done via the United provider portal*
Wellpoint	Wellpoint PM	Wellpoint PA

DOCUMENTATION – PROOF OF DELIVERY (MCO)

- MCOs confirm delivery through:
  - Retrospective reviews
  - Care manager roles
  - Member outreach

- Proof of delivery to be made available upon request.

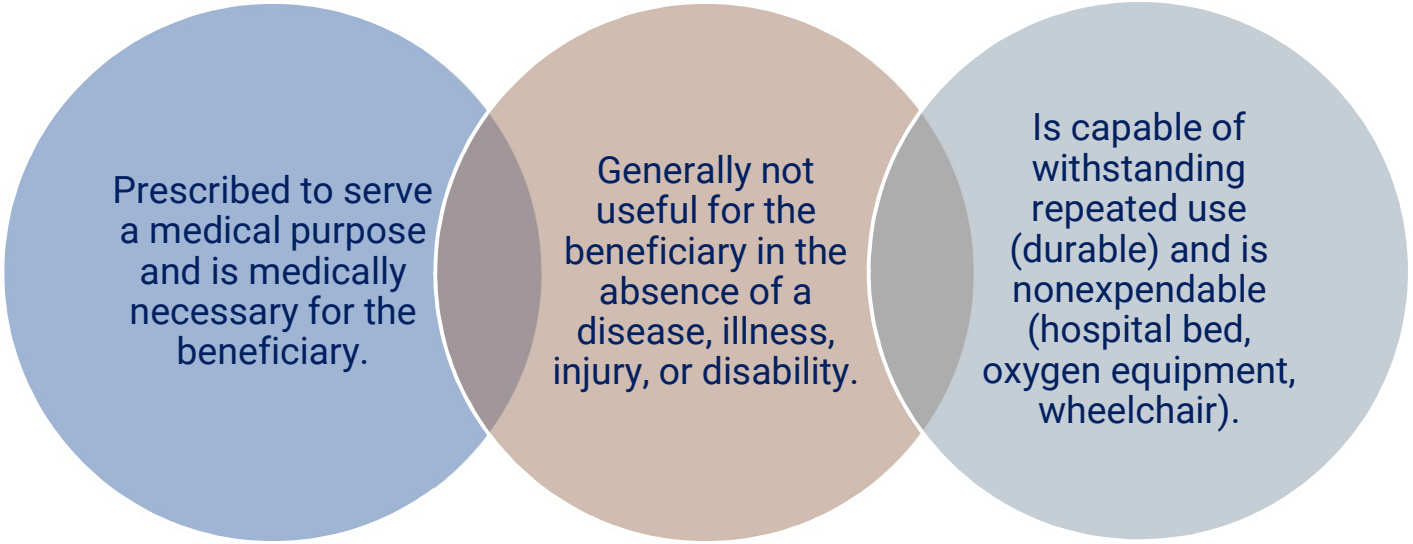
BILLING GUIDELINES

Presented by: Cesar Anicama, Manager, Network & Physician Contracting
Horizon Blue Cross Blue Shield of New Jersey

BILLING GUIDELINES (FFS AND MCO)

N.J.A.C. 10.59-1.2

As a condition of reimbursement, DME is defined as an item or apparatus, other than hearing aids and certain prosthetic and orthotic devices, including customized DME, modified DME and standard DME, which has all the following characteristics:



BILLING GUIDELINES (FFS AND MCO)

N.J.A.C 10:59-1.8

- Established Medicaid/NJ Family Care fee schedule - bill electronically using HIPAA compliant code for the product provided.
- No established fee - must supply one of the two items with the bill:

Manufacturer/Supplier Invoice

- Shall contain:
  - the addressee;
  - item description; and
  - quantity and cost
  - Must be on proper letterhead.

NJ Medicaid Maximum Fee Allowance

- Shall include:
  - manufacturer's name;
  - item description; and
  - suggest retail price per unit or package.
- Include number of units per package if not described by the manufacturer

BILLING GUIDELINES (FFS AND MCO)

- Claims will pay based only on eligible charges.
- Under New Jersey law, claims must meet the following criteria:

Health care provider - eligible at date of service

Person receiving service - covered on date of service

Claim is a covered service/supply benefit

Claim is submitted with all required information in accordance with section 5 of P.L.2023, c.296 (C.17B:30-55.4)

Payor has no reason to believe the claim was submitted fraudulently

BILLING GUIDELINES – RENTAL REIMBURSEMENT (FFS)

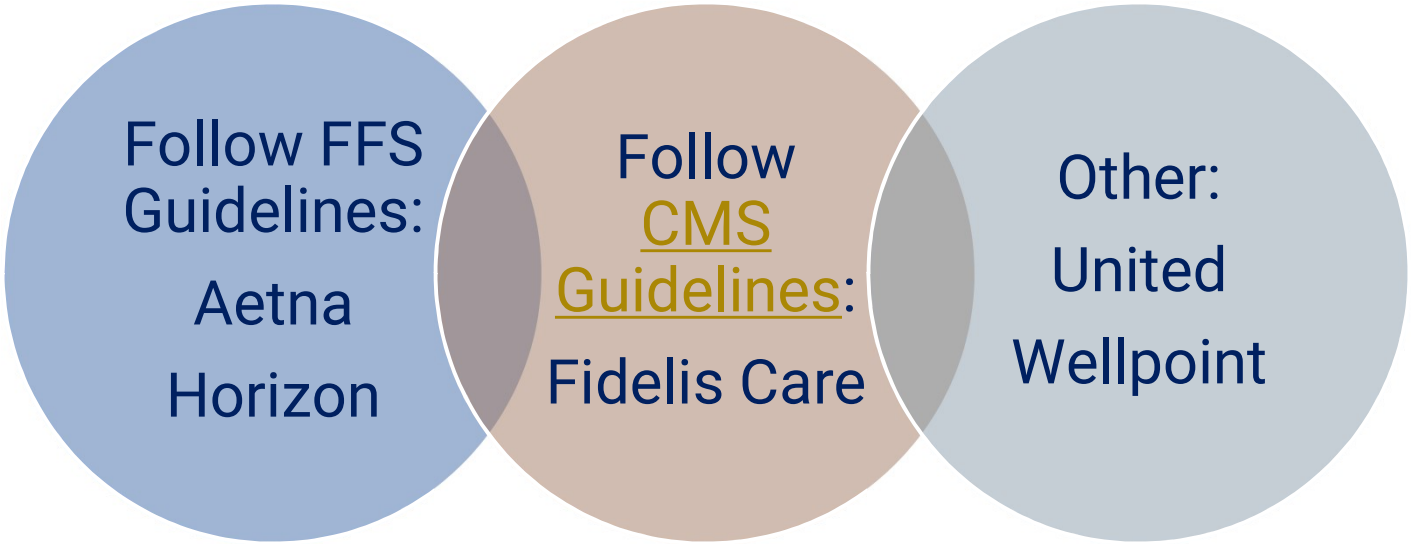
Medical equipment item (max fee allowance $100 or less)	• Monthly rental payment is the amount billed, or 20% of the approved purchase price, whichever is less. • Six such payments shall be deemed the full purchase price. • No further payments shall be made and the equipment will be considered the property of the State.
Medical equipment item (max fee allowance more than $100)	• Monthly rental payment is the amount billed, or 12% of the fee, whichever is less. • Ten such payments shall be deemed to be the full purchase price and no further payments shall be made and the equipment will be considered the property of the State.

BILLING GUIDELINES – RENTAL REIMBURSEMENT (FFS)

If purchase of rental item is authorized prior to the close of the maximum rental period (see N.J.A.C. 10:59-1.8(b)1 and 2)	• A final payment will be made which equals the difference between the sum of the prior rental payments and the maximum fee allowance.
If death, ineligibility, or other circumstances over which the New Jersey Medicaid has no control	• Rental fees for any medical equipment item shall terminate at the end of the month such circumstance(s) occur and no further payment will be made.

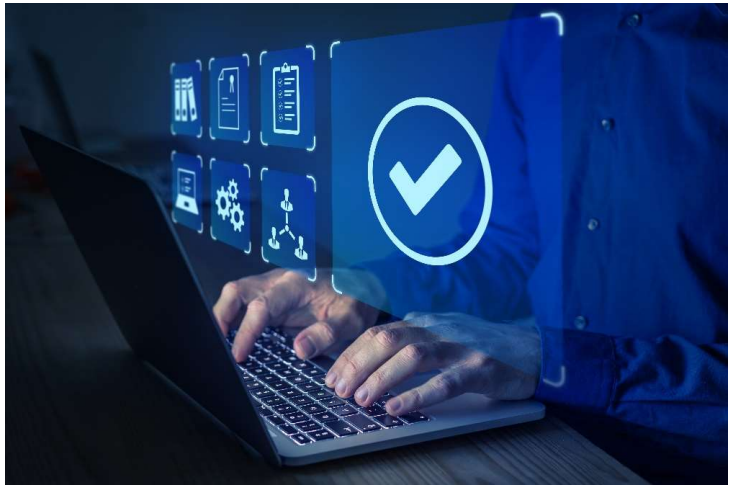
BILLING GUIDELINES – RENTAL REIMBURSEMENT (MCO)

Capped rentals vary by MCO



BILLING GUIDELINES (FFS AND MCO)

- All services rendered - must be submitted on:
  - CMS 1500 (HCFA1500) version 02/12; or
  - UB-04 claims form; or
  - Via electronic submission in a HIPAA compliant 837 or NCPDP format.
- Claims forms and electronic submissions must be consistent with the instructions provided by CMS requirements, as stated in the CMS Claims Manual.



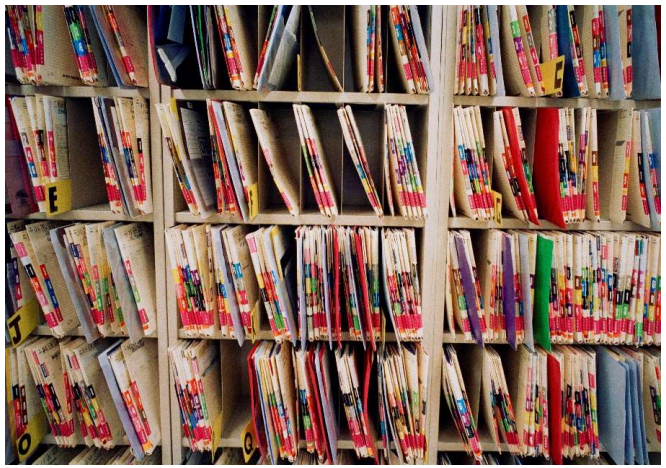
BILLING GUIDELINES – BALANCE BILLING (FFS AND MCO)

- If a provider receives a Medicaid FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

RECORDS RETENTION

RECORDS RETENTION
N.J.S.A. 30:4D-12(D)

- To retain individual patient records for a minimum period of five years from the date the service was rendered.
- If contracted with Horizon NJ Health:
  - HNJH requires records retention for the later of ten years from the date the service was rendered, or after the final payment is made and all pending matters are closed.



COMPLIANCE AND THE MEDICAID FRAUD DIVISION

Presented by: Tracy Livingston, Assistant Director, Data and Fiscal,
Office of the State Comptroller, Medicaid Fraud Division

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

- New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. 30:4D-53 et seq.
  - Established the Office of the Medicaid Inspector General to detect, prevent, and investigate Medicaid fraud and abuse, recover improperly expended Medicaid funds, enforce Medicaid rules and regulations, audit cost reports and claims, and review quality of care given to Medicaid recipients.
- These functions, powers and duties were later transferred to the Office of the State Comptroller (OSC), and are carried out by the Medicaid Fraud Division (MFD).

PROGRAM INTEGRITY (PI) OVERSIGHT

- Refers to the system of monitoring and auditing NJ Medicaid providers to ensure they are:
  - billing Medicaid accurately;
  - delivering appropriate services;
  - not engaging in fraudulent practices, abusive, or wasteful practices; and
  - properly documenting the goods/services billed.

MFD OVERSIGHT FUNCTIONS

Program Integrity Oversight

Enforce Medicaid rules and regulations	Audit and investigate potential fraud, waste and abuse by providers and recipients	Recover improperly expended Medicaid funds	Coordinate PI oversight efforts among State agencies that provide and administer Medicaid services and programs.	Exclude or terminate providers from the Medicaid program where necessary

WHY IS PI OVERSIGHT IMPORTANT?

Protecting Medicaid Funds

- ensures Medicaid dollars are used effectively to provide quality care to eligible individuals.

Maintaining Quality of Care

- ensures that durable medical equipment providers are delivering appropriate and necessary services to patients.

CONSEQUENCES

Non-compliance with Medicaid rules, standards and regulations regarding service may constitute acts of fraud, waste or abuse of Medicaid funds.

MEDICAID FRAUD DIVISION: ACTIONS, INELIGIBLE PROVIDERS, SELF-DISCLOSURES, AND THIRD PARTY LIABILITY

Presented by: Khia O'Neal, CPC, CPMA Assistant Division Director, Investigations,
Office of the State Comptroller, Medicaid Fraud Division

MFD RECOVERY ACTIONS

- Once an overpayment has been identified as a result of an investigation or audit, MFD initiates actions for recoupment of improperly paid funds.

Send notice of Estimated Overpayment, Notice of Intent and, Notice of Claim

Add penalties, including false claim penalties between $13,946 and $27,894 per claim

File a Certificate of Debt on real estate owned by a provider/owner of business

Seek to withhold future Medicaid payments until overpayment is satisfied

INELIGIBLE PROVIDERS

- An ineligible provider - someone who is excluded from participation in Federal or State funded health care programs.
  - Debarred, disqualified, suspended, or excluded providers are considered ineligible providers.
- Any products or services that an ineligible provider directly or indirectly furnishes, orders or prescribes - not eligible for payment under those programs (N.J.A.C. 10:49-11.1(b)).
- It is incumbent upon providers to perform Ineligible Provider Checks, upon hire and monthly thereafter:
  - NJMMIS Newsletter Volume 33, Number 02

MEDICAID INELIGIBLE PROVIDER LIST REQUIREMENTS

1. State of New Jersey Ineligible Provider report (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
2. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
3. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
4. N.J. Division of Consumer Affairs licensure databases (mandatory): http://www.njconsumeraffairs.gov/Pages/verification.aspx
5. N.J. Department of Health licensure database (mandatory):http://www.state.nj.us/health/guide/find-select-provider/
6. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp
7. If the provider is out of state, you must also check that state's exclusion/debarment list

SELF-DISCLOSURE

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://nj.gov/comptroller/resources/#collapseSub30/

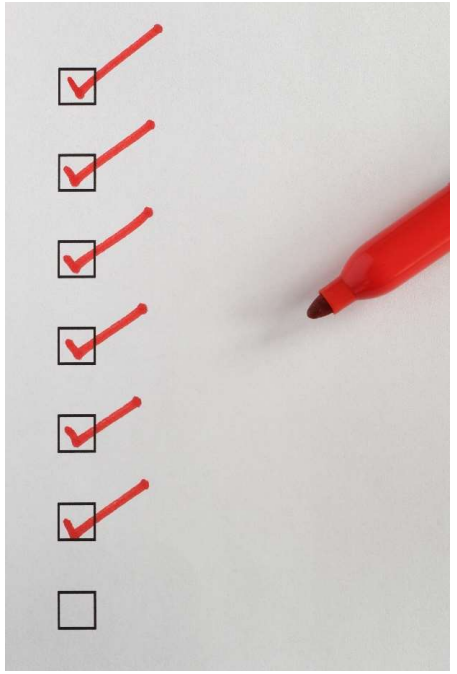
- Affordable Care Act §6402 and N.J.A.C. §10:49-1.5 (b)(1), (7)
  - require that any overpayments from Medicaid and/or Medicare must be returned within 60 days of identifying that they have been improperly received.

- Providers who follow the protocols for a proper self-disclosure can avoid imposition of penalties.

- MFD's Self Disclosure Form: https://nj.gov/comptroller/news/docs/self_disclosure_form.pdf

SELF-DISCLOSURES – MUST INCLUDE:

- A summary of the identified issue(s) including the underlying cause;
- The Medicaid program rules potentially implicated;
- The nature and extent of any investigation or audit conducted to identify and determine the amount of overpayment;
- All corrective action(s) taken;
- An Excel file including a detailed list of claims paid that comprise the overpayments;
- An attestation of accuracy and completeness; and
- The name and contact information of the individual making the report on behalf of the provider.



SELF-DISCLOSURE: STATISTICAL SAMPLING & EXTRAPOLATION

- If the self-disclosure involves statistical sampling and extrapolation:
  - Work must be performed by qualified personnel.
  - Provide an Excel file containing, at a minimum, the:
    - Sampling Plan;
    - Universe/ Sampling Frame;
    - Sample with the results of the Sample Review (i.e., for each claim indicate if it is in error, explain what the error is, and explain how much money should have been paid/ how much money was overpaid);
    - Random Numbers (used to select random sample) / Seed Number (to replicate sample);
    - Extrapolation Methodology / Output; and
    - Explanation or description of all software used to perform the sample and extrapolation.

SELF-DISCLOSURE: SAMPLING & EXTRAPOLATION RESOURCES

- OIG Self-Disclosure Protocol (discusses Sampling/ Extrapolation on pages 6-8)
  - https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/
- OIG Statistical Sampling and Extrapolation Software: RAT-STATS
  - https://oig.hhs.gov/compliance/rat-stats/
- Medicaid Fraud Control Unit (MFCU) Sampling Guidance
  - https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/MFCU-Sampling-Guidance.pdf
- CMS Medicare Program Integrity Manual (MPIM), Chapter 8 – Statistical Sampling for Overpayment Estimation
  - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c08.pdf

THIRD-PARTY LIABILITY (TPL)

- Third-Party Liability - when any entity or party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program.
  - Examples: Medicare, commercial health insurance, Tricare
- By law, Medicaid is the payer of last resort. All TPL shall, if available, be used first and to the fullest extent to pay claims before Medicaid/NJ FamilyCare pays for the care of the Medicaid recipient.
- It is a violation of Section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services (N.J.A.C. 10:49-7.3).

Name	Contact Information
TPL Hotline	(609) 826-4702
TPL Hotline en Español	(609) 777-2753

WHAT IS: FRAUD, WASTE, AND ABUSE (FWA)?

Presented by: Brittney Sichel, CPC, Investigations Consultant
UnitedHealthcare Investigations

WHAT IS FWA?

Fraud

- N.J.S.A. 30:4D-55
- An intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit.

Waste

- Considered a legal violation for civil purposes and can result in a recovery of an overpayment, debarment from the Medicaid program and penalties.
- Not *usually* considered a criminal act.

Abuse

- N.J.S.A. 30:4D-55
- Provider practices that are inconsistent with proper, sound fiscal, business, or professional or service delivery practices.
- Practices that result in:
  - unnecessary costs to or improper payment by Medicaid; or
  - reimbursement for services that are not necessary, not approved, not documented, that are outside those specifically authorized.

FWA - EXAMPLES

Fraud

- billing for services not rendered
- billing for services while the member is inpatient
- transportation time used as time spent onsite

Waste

- overutilization
- misuse of resources
- overuse of supplies
- billing for services that are not medically necessary

Abuse

- services billed exceed the prior authorized approved amount

CIVIL MEDICAID FRAUD, WASTE AND ABUSE - CONSEQUENCES

- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Referral for criminal prosecution
- Restitution/Recovery of overpayments
- Additional penalties in addition to repaying Medicaid overpayments

RED FLAGS AND CASE EXAMPLES

Presented by: Haley Everson, AHFI, Manager, Special Investigations Unit
Elevance Health (Wellpoint)

RED FLAG AREAS

Issue	Description	Red Flags and Examples
Misrepresentation of Services	Miscoding - stating that A was given when it was actually B	Red Flags: Changes in diagnosis codes for non-covered services Examples: Suppliers deliver an off the shelf product but bill for custom fitted products

RED FLAG AREAS

Issue	Description	Red Flags and Examples
Upcoding	Charging for more expensive services	Red Flags: Claims data analysis of outlier providers Examples: Billing of miscellaneous DME codes where there is an appropriate code available to use

RED FLAG AREAS

Issue	Description	Red Flags and Examples
Billing for services not rendered	Submitting claims for items never received	Red Flags: • Member complaints • Photocopied orders repeatedly submitted with new DOS appended from same provider Examples: • Maintenance charges for equipment where maintenance was never provided • No proof of delivery for billed items

RED FLAG AREAS

Issue	Description	Red Flags and Examples
Unnecessary / Excess Care	Supplying more than needed for reimbursement	Red Flags: • Telemarketers outreach members without physician involvement • Members request services online based on advertisements • Physician prescribing has no relationship to member Examples: • Urinary Catheters • Orthotic Braces (back and knee are the most common) • Diabetic Testing Supplies

OXYGEN TANK AND CPAP DEVICES

- Be familiar with policies and guidance for oxygen and CPAP devices including:
  - What is included in the member's benefit plan
  - Requirements for medical necessity
  - Billing limits (may be based on number of months rented, or purchase price)
  - What codes can, and cannot, be billed together

MEDICAID FRAUD CONTROL UNIT (MFCU)

Presented by: Sergeant Michael Rosati,
Medicaid Fraud Control Unit

MEDICAID FRAUD CONTROL UNIT (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud (OIFP) is the criminal oversight entity.

- MFCU investigates and prosecutes Medicaid Fraud.

- The MFCU utilizes attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

MEDICAID FRAUD CONTROL UNIT (MFCU)

- The MFCU investigates and prosecutes alleged criminal actions:
  - Allegations of physical abuse to beneficiaries.
  - Fraudulent activities by providers against the Medicaid program.
  - Fraud in the administration of the program.
  - Fraud against other federally or state funded health care programs where there is a Medicaid nexus.

CRIMINAL HEALTH CARE CLAIMS FRAUD

N.J.S.A. 2C:21-4.3

- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims.
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license

FALSE CLAIMS

Did you know…

- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.

MEDICAID FRAUD: IN THE NEWS

Owners of Medical Equipment Supply Store Sentenced to Prison for Stealing over $100,000 through Medicaid Fraud Scam

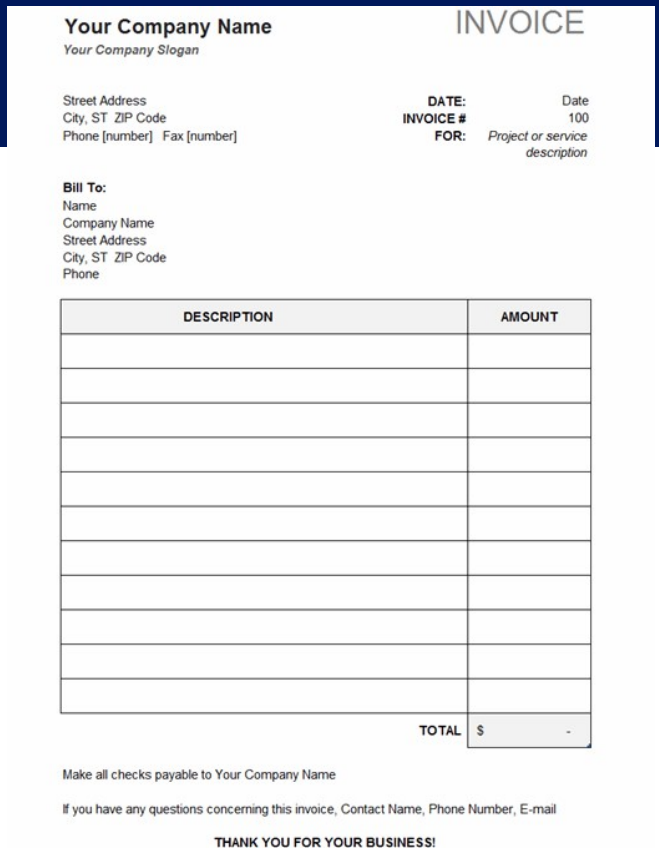
- An audit was conducted of Medicaid claims submitted by a DME company specializing in orthopedic footwear.
- During their onsite review, auditors noticed that most of the shoes displayed in the store appeared to be regular shoes, rather than orthopedic footwear.
- The matter was referred to MFCU for further investigation.

MEDICAID FRAUD: INVESTIGATION

- Patient interviews and examination of medical supplies provided by the DME company.
- The NJ Division of Medical Assistance and Health Services (Medicaid) provided a shoe expert to examine the shoes that were dispensed.
- This expert found that most of the shoes reviewed were comfort shoes, rather than orthopedic. The expert also noted that the provider was dispensing regular stockings instead of medical compression stockings.

- Certain DME items are reimbursed by Medicaid at cost plus a fixed profit. Invoices are submitted to Medicaid as proof of cost.

- The investigation identified the use of fictitious invoices.
  - Item descriptions;
  - Payment amounts; and
  - Fictitious suppliers.



Your Company Name
Your Company Slogan

INVOICE

Street Address
City, ST ZIP Code
Phone [number] Fax [number]

DATE: Date
INVOICE # 100
FOR: *Project or service description*

Bill To:
Name
Company Name
Street Address
City, ST ZIP Code
Phone

DESCRIPTION	AMOUNT
TOTAL	$ -

Make all checks payable to Your Company Name

If you have any questions concerning this invoice, Contact Name, Phone Number, E-mail

THANK YOU FOR YOUR BUSINESS!

MEDICAID FRAUD: OUTCOME & PENALTIES

- The two owners pled guilty to second-degree Health Care Claims Fraud:
  - Sentenced to three-years in state prison.
  - Eight-year debarment from participation in any government funded health insurance program.
  - Ordered to pay $300,000 in restitution and penalties.

Bottom line:

Ignorance of the law excuses no one.

It is the provider’s responsibility to know the laws.

WRAP UP

FRAUD, WASTE, AND ABUSE REPORTING

Name	Contact Number	FWA Reporting Website
Aetna Better Health of New Jersey	(855) 282-8272	Aetna FWA Reporting
Fidelis Care	(866) 685-8664	Fidelis Care FWA Reporting
Horizon NJ Health	(855) 372-8320	HNJH FWA Reporting
UnitedHealthcare Community Plan	(844) 359-7736	UHC FWA Reporting
Wellpoint	(866) 847-8247	Wellpoint FWA Reporting
Division of Medical Assistance and Health Services	(609) 588-2739	Puneet.Kumar@dhs.nj.gov
NJ Office of the State Comptroller, Medicaid Fraud Division	(888) 937-2835	MFD FWA Reporting
NJ Medicaid Fraud Control Unit	(609) 292-1272	NJMFCU@njdcj.org

QUESTIONS? PLEASE CONTACT US!

- Division of Medical Assistance and Health Services (DMAHS)
  - Email: Puneet.Kumar@dhs.nj.gov, Physician Specialist
  - Phone: Angela Bowe, Senior Administrative Staff Specialist @ (609)588-2739
- Medicaid Fraud Division (MFD)
  - Email: provider-education@osc.nj.gov
  - Website: https://nj.gov/comptroller/about/work/medicaid/
- Medicaid Fraud Control Unit (MFCU)
  - Email: NJMFCU@njdcj.org
  - Website: https://www.njoag.gov/about/divisions-and-offices/office-of-the-insurance-fraud-prosecutor-home/medicaid-fraud-control-unit/

QUESTIONS?

Any questions we are unable to answer today, please submit in writing to:

provider-education@osc.nj.gov

HOW DID WE DO?

Please respond to a brief poll to help us know how we did!

KEEP IN TOUCH

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