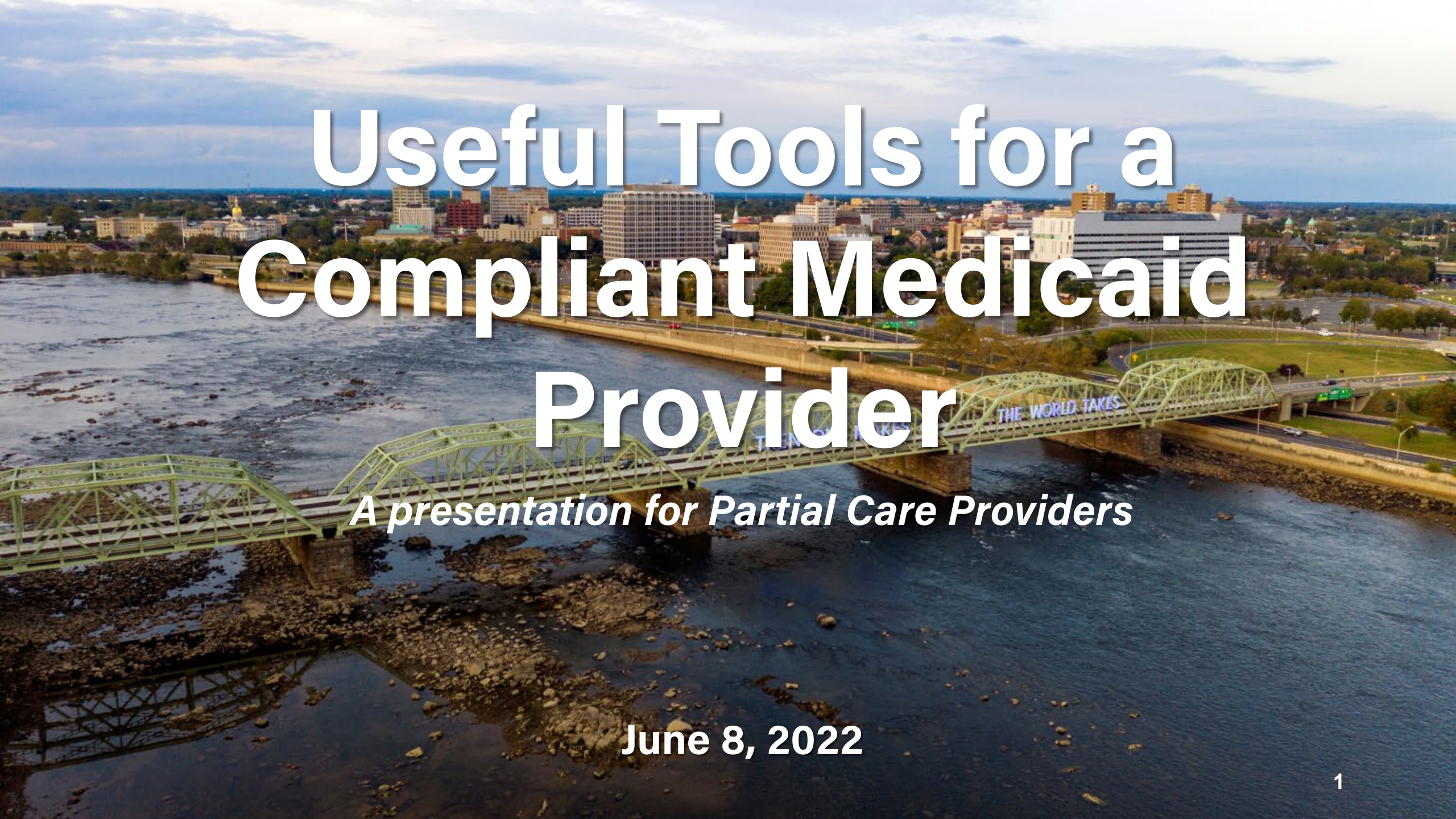


Useful Tools for a Compliant Medicaid Provider

A presentation for Partial Care Providers

June 8, 2022

Presented in Partnership by:

- Department of Human Services, Division of Mental Health and Addiction Services (DMHAS)
- Department of Human Services, Division of Medical Assistance and Health Services (DMAHS)
- Office of the State Comptroller, Medicaid Fraud Division (MFD)
- Office of the Insurance Fraud Prosecutor, Medicaid Fraud Control Unit (MFCU)
- NJ FamilyCare's Managed Care Organizations (MCOs)

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.

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).

Goals for Today

To help you better understand:

- Partial Care provider's responsibilities for Medicaid compliance
- The Medicaid regulatory framework and program integrity oversight
- Medicaid documentation requirements for payment
- Provider obligation to avoid fraud, waste or abuse of Medicaid funds
- Consequences for non-compliance

Questions?

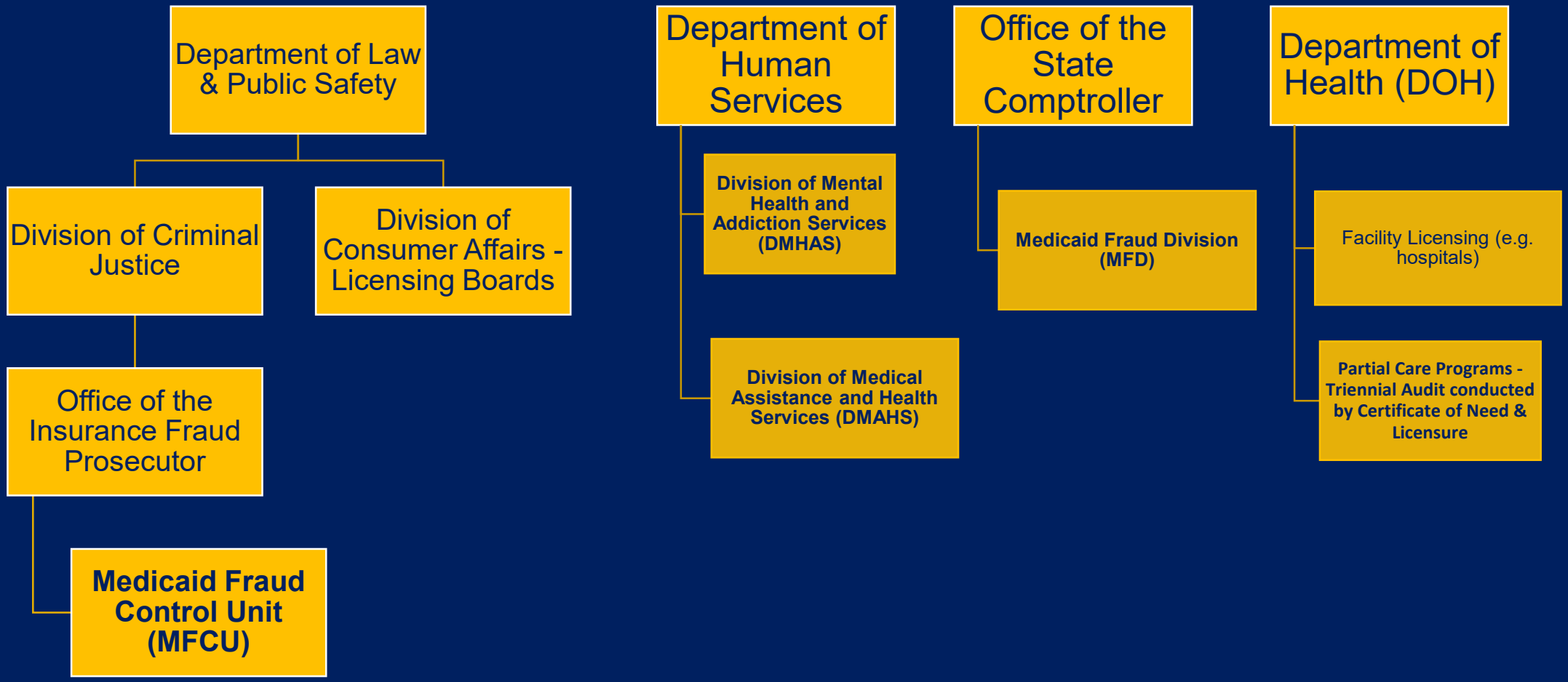
If you have questions throughout the course of the presentation please put them in the Q & A.

What is Medicaid?

- Medicaid is 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. Your continued participation requires compliance with the regulatory requirements.

New Jersey Agency Administration and Medicaid Oversight



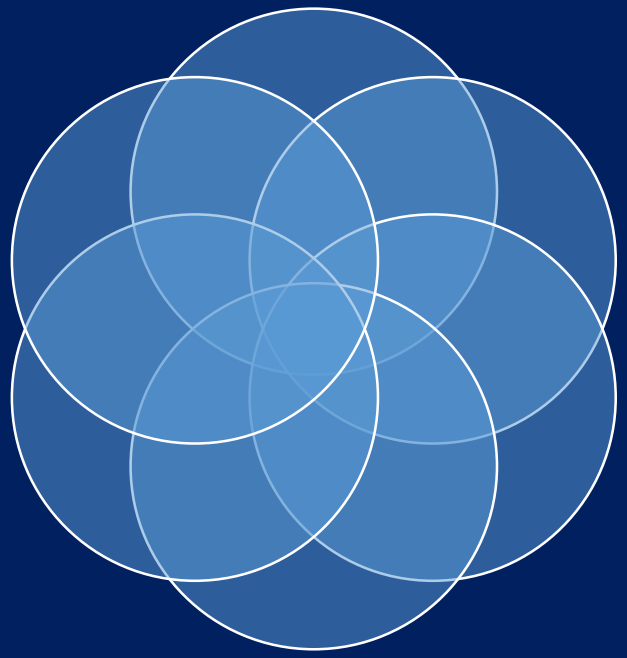
Division of Mental Health and Addiction Services - Mission

DMHAS, in partnership with consumers, family members, providers and other stakeholders, promotes wellness and recovery for individuals managing a mental illness, substance use disorder or co-occurring disorder through a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well trained workforce.

Persons with Mental Illness

Developmentally Disabled

Children/ Adolescents



Incarcerated/ Detainees

Aging/ Seniors

Co-occurring Disorders

Homeless

Continuum of Mental Health Services

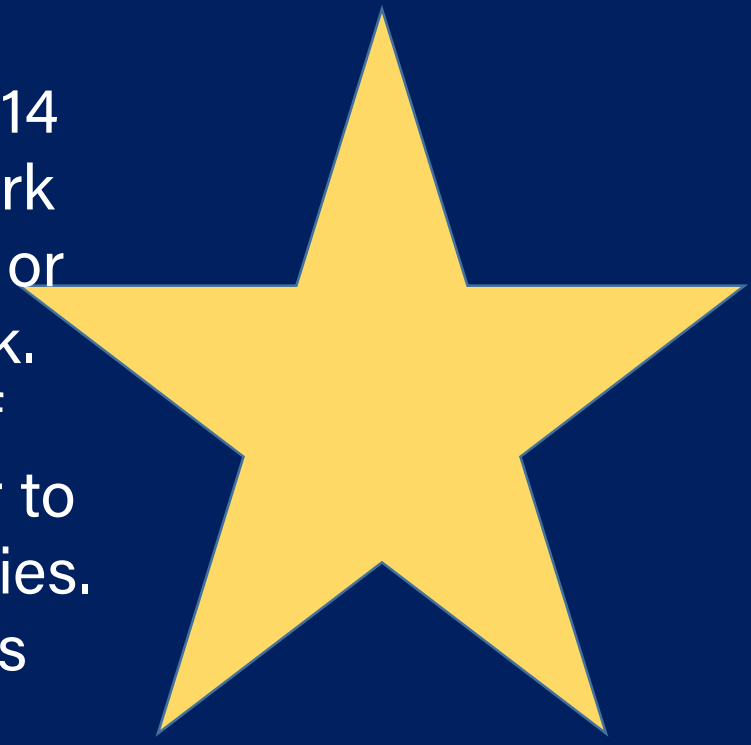
- Screening and Crisis Intervention
- Inpatient Treatment
- Outpatient Treatment
- Rehabilitative Services
  - Partial Care: Up to five hours per day, five days per week, group-based services, with medication management and transportation included
- Advocacy, Linkage and other supports
- Self-Help

Partial Care Services

In New Jersey, Partial Care services for Medicaid (NJ FamilyCare) recipients are provided primarily through Fee-For-Service, with some special populations covered through Managed Care.

21st Century Cures Act Section 5005(B) (2)

- Effective January 1, 2018 the 21st Century Cures Act 114 P.L. 255, requires all Medicaid Managed Care network providers to enroll with the State Medicaid program or risk being removed from the Managed Care Network.
- Enrollment in the State Medicaid Program as part of 21st Century Cures Act does not require the Provider to accept NJ Medicaid Fee for Service (FFS) beneficiaries.
- Enrollment as a 21st Century Cures Act Provider does not allow a Provider to bill Fee for Service Medicaid.
- Newsletter Volume 30 Number 18



Medicaid Managed Care Contract

DMAHS has a contract with the following MCOs:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare Health Plans of NJ, Inc.

Partial Care Services Covered by MCOs

- Partial Care is covered by FFS Medicaid for Core Medicaid members.
- Currently, only special populations are covered by MCOs for Partial Care:
  - MLTSS- Managed Long Term Services and Support
  - DDD- Division of Development Disabilities
  - FIDE SNP- Fully Integrated Dual Eligible Special Needs Program
- These special populations must receive their Partial Care services from providers who are contracted with the member's managed care plan.
- The Partial Care benefit is the same benefit as FFS.
- Partial Care billing code is H0035.

Partial Care Services Covered by MCOs

- Services may be subject to Prior Authorization per individual MCO requirements. It is the provider's responsibility to obtain prior authorization.

- Each authorization will have a reference number, type of service and/or specific billing code, start and end date, and a certain number of units.
  - For example: reference #NJ123456, dates 1/1/2022 – 3/31/2022, for 325 units, code H0035

- Know your authorization details and when updated clinical is due for concurrent review.

Partial Care Services Covered by MCOs

- Services are limited to 5 hours a day, 25 hours a week.
- Partial Care Transportation is reimbursed through FFS for all members, including the special populations, the transportation service code Z0330.
- As part of the proposed 1115 waiver, Partial Care services would be covered by MCOS for total Medicaid population.

Guiding Regulations – Partial Care Services

- Regulation N.J.A.C. 10:66-2.7 (DMAHS)
- Regulation N.J.A.C. 10:37F (DMHAS)
- Regulation N.J.A.C. 3A:58 (DCF)

- Newsletters are used to introduce new programs or services, pending regulatory updates or general program guidance.

- Newsletters can be found on www.njmmis.com.

Guiding Regulation – Partial Care Services

- As Partial Care providers, it is your responsibility to observe these regulations

- Regulations dictate:
  - Who can provide services
  - Who can receive services
  - Limits on services
  - Allowable vs. non-allowable services
  - Documentation requirements
  - Frequency guidelines
  - Billing codes

Public Health Emergency (PHE)

- DOH health care provider requirements
  - 6 ft spacing
  - Masks
  - Mandatory vaccines for staff

- Telehealth-currently allowed in response to PHE.
  - Newsletter Volume 30 Number 11

- Telehealth law (2021)- guidance after current waivers affecting telehealth are lifted.

Six Steps Towards Compliance

1. Providing the clinically appropriate service as identified in the treatment plan
2. Accurately documenting the services - who, what, where, when and how
3. Instituting Responsible Billing Practices
4. Properly Supervising all Employees' Provision of Services
5. Establishing a System to Identify and Correct Errors and Omissions concerning Credentialing, Documentation and Billing
6. Adhering to Waiver and Regulatory Standards, where applicable, including hiring practices, properly completing Medicaid application, and training yourself and all staff about their requirements

Accurately Documenting Services

Documentation requirements arise from a variety of sources:

- -Statutes (State and Federal)
- -State Medicaid Regulations and Newsletters
- -State Professional Board Regulations
- -Federal Regulations
- -CMS Guidelines and Policies
- -MCO Provider Contracts, Manuals, Provider Agreements, Newsletters, etc.
- -Procedure (Billing) Codes
- -Best Practices

Accurately Documenting Services

Documentation should occur at the same time as the services rendered.

It is the provider’s responsibility to know and comply with documentation requirements.

Records Retention Timelines

Timelines vary depending upon the source:

- N.J.A.C. 10:37-6.77
- Records of adults must be retained 5 years after the last date of service;
- Records of children must be retained 5 years after they reach their 18th birthday.
- Article 7.28.A of the MCO contract: 10 years

Follow the regulation with the greatest length of time that pertains to you!

Medicaid Documentation Requirements

Providers shall agree to the following:

- To keep such records necessary to fully disclose the extent of services provided, and to retain individual records for the greatest length of time that applies from the date the service was rendered;

- To timely furnish information about such services as requested by regulatory agencies, including the Medicaid Fraud Division;

- If records do not document the type and extent of services billed, payment adjustments are necessary, including requiring repayment to Medicaid or claim payment denial.

Documentation Requirements – Forms and Formats

- There are generally two types of medical records; handwritten or Electronic Health Records (EHR).
- Regardless of the type, the content must be accurate and complete.
- It must:
  - Record the diagnosis;
  - Fully disclose the kind and extent of the service(s) provided, as as the medical necessity for the service; and
  - Include notes about what occurred and when appropriate, expected outcomes.
- Records must document all services billed, including time if required for the billing code.

Documentation Requirements – Forms and Formats

- Accurate notes of services are important for:
  - Continuity of care by other providers and
  - To properly support that the services billed were rendered

- Progress Notes and Billing Records are two distinct documents. Both may be requested at times.

Documentation

All records / documentation used to support billing must be individualized, reflect actual services delivered, and include:

- Individual's name
- Date of service/time/duration
- The specific services rendered, such as individua group or family psychotherapy, etc.
- Description of the encounter and notation of unusual occurrences
- Signature of person authoring the note
- Signature of supervisor if required

Documentation

Record must reflect all elements for which provider bills:

- Should be done at the time services are rendered, or as close to that as possible
- Time based codes require documentation of time (documentation of time can be on a separate document in the patient record)

If Using Handwritten Records

- Content and signature in notes must be legible

Documentation

Notes MUST:

- Align with the service or treatment plan's outcomes and strategies.
- Answer the who, what, when, where and why of service provision.
- Be completed by either the individual providing the service OR an individual responsible for the oversight of the direct service provision.
  - If the note is completed by a staff member not providing the direct service, they should have documentation to support the information contained in the note.
- Reflect progress toward or decline from identified outcomes.
- Comply with Partial Care requirements as detailed by N.J.A.C. 10:66-2.7 and N.J.A.C. 10:37F.

Documentation

Notes MUST:

- Providers using an electronic health record (EHR) or other electronic system must ensure that all information required in mandatory sections is included and individualized for the recipient and that all underlying documentation can be produced to support services rendered during an audit or investigation.

Documentation

Notes CANNOT:

- Be completed by a staff person not connected to the service provision
- Be duplicative or generic in nature

Documentation

- ✓Records/documentation must accurately reflect the services that were rendered.
- ✓Documentation should occur at the same time as services rendered.
- ✓Medicaid will not pay for undocumented or improperly documented services.

Documentation

Don’t shortchange yourself...
If it’s not documented or not documented correctly,
it wasn’t done!

Chart Requirements

- ✓Legible entries
- ✓Psychiatric Evaluation/Intake within 14 days of initial date of service
- ✓Plan of Care (POC) (clinical findings and diagnosis) discussed and accepted by patient, Medical Director and licensed clinician
  - Periodic review of the POC every 90 days during first year and every 6 months thereafter
- ✓Prior Authorization obtained every six months, and billing should not exceed prior authorized number of units/amount

Chart Requirements – Cont.

- ✓Clinician sign/initial entries
- ✓Informed consents present, where necessary
- ✓Daily group notes
- ✓Weekly progress notes
- ✓Accurate description of treatment documented
- ✓All services billed were performed as documented

Billing Guidelines

- All Partial Care services must be Prior Authorized.
- Partial Care services are billable per hour:
  - Maximum billing - five hours a day
  - Minimum billing - two hours a day
- If the number of hours of service provided is fractional, the units should be rounded down to the lower whole number.
- Billing for Partial Care service is for active programing that is exclusive of meals, breaks and transportation.

Institute Responsible Billing Practices

Billing and Coding

- The use of specific codes by the provider that accurately report the services rendered are required to receive payment for those services

- The codes that are used on the claim form are:
  - H0035
  - H0035GTUC/telehealth
  - Z0330- one way transportation

Responsible Billing Practices

- It is the **Provider's** responsibility to ensure that claims submitted for payment reflect:
  - ✓the actual service that was provided;
  - ✓who performed the service,
  - ✓the location of the service;
  - ✓the billing entity; and
  - ✓the time duration for claims that are time-based

- It is incumbent upon **Providers** to be knowledgeable regarding the codes that are used to reflect the services rendered.

Identify and Correct Errors

- Implement a robust system of quality assurance and oversight that reviews compliance on an ongoing basis and adjusts service delivery to maintain outlined standards.

- Supplemental documentation to a note can be added if necessary, as long as the date of the addition is included as well as the initials of the person supplementing the record.

Regulatory Standards

Provider is responsible to verify with documentation that:

- Staff is qualified and trained - verify credentials, certification, licenses, establish training schedule
- Background check performed ensuring that new or potential staff have no disqualifying criminal issues before permitting provision of services
- Exclusion checks must be performed monthly
  - NJMMIS Newsletter Volume 26, Number 14

Consequences

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

About the Medicaid Fraud Division (MFD)

The 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).

About the Medicaid Fraud Division

The Medicaid Fraud Division performs program integrity functions, conducts audits and investigations of potential fraud, waste and abuse by providers and recipients, and coordinates program integrity oversight efforts among all State agencies that provide and administer Medicaid services and programs.

About the Medicaid Fraud Division

The Medicaid Fraud Division also works to recover improperly expended Medicaid funds, enforces Medicaid rules and regulations, audits cost reports and claims, reviews the quality of care given to Medicaid recipients, and excludes or terminates providers from the Medicaid program where necessary.

Fraud

N.J.S.A. 30:4D-55

Fraud – is an intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit to that person or another person, including any act that constitutes fraud under applicable federal or State law.

Civil Medicaid Fraud, Waste and Abuse Consequences

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

Waste

- *Waste* is generally understood to encompass overutilization or the misuse of resources.
- Waste is not *usually* considered a criminal act.
- Waste is considered a legal violation for civil purposes and can result in a recovery of an overpayment, debarment from the Medicaid program and penalties.

Abuse

N.J.S.A. 30:4D-55

Abuse - provider practices that are inconsistent with proper, sound fiscal, business, or professional or service delivery 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.

Waste and Abuse

Professional Due Diligence

Business practices that result in **waste and abuse c**an rise to the level of f**raud:**

- Providing service without proper authorization (unless it is emergent care)
- Using unlicensed, unqualified, or untrained staff
- Inaccurate / incomplete documentation of service
- Billing for undocumented / unsubstantiated services
- Insufficient internal checks and balances

Examples of Partial Care FWA

- Upcoding
- Misrepresentation in rendering provider
- Billing for:
  - Services Not Rendered
  - Overlapping session times
  - Multiple family members for the same family therapy session

Example of Inappropriate Findings

- Claim date of service not matching chart entry
- Non-credentialed providers treating members
- Signatures not dated
- Missing time and service duration
- Reporting participant’s presence in multiple groups offered at the same time

Example of Inappropriate Findings – Cont.

- Reporting participant's presence at the group sessions offered prior/past participant's arrival/departure time
- Two separate facilities billing for partial care services on the same day for the same member
- Billing for partial care services during Meal Time
- Billing for Intake Assessment on the same day with Partial Care Services 90791/90792 with PCP
- Billing Evaluation/Management codes for routine follow up visits included in the Partial Care Provider bundled rate

Examples: MFD Partial Care Audit Findings

- Lack of documentation supporting billing for active programming
- Meal time included in the billing for active programming
- Billing for active programming during participant's absence
- Documentation lacking: date, time and duration of service, and provider's signature
- Participant's group attendance recorded prior to arrival/departure to/from the facility
- Participant's group attendance recorded for the two classes offered at the same time

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:

- ✓MFD will send a Notice of Estimated Overpayment or Notice of Intent and, if necessary, a Notice of Claim
- ✓MFD may add penalties, including false claim penalties between $11,181 and $22,363 per claim
- ✓MFD may file a Certificate of Debt on real estate property owned by a provider/owner of business
- ✓MFD may seek a Withholding of future Medicaid payments until the overpayment is satisfied

Excluded, Suspended or Disqualified Providers

- A debarred, suspended or excluded provider is a person or an organization that has been excluded from participation in Federal or State funded health care programs

- Any products or services that a debarred provider directly or indirectly furnishes, orders or prescribes are not eligible for payment under those programs

- It is incumbent upon providers to perform Exclusion Checks, upon hire and monthly thereafter
  - NJMMIS Newsletter Volume 26, Number 14

Medicaid Exclusion List Requirements

MFD Exclusion List Requirements:

- State of New Jersey debarment list (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
- Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
- N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
- N.J. Division of Consumer Affairs licensure databases (mandatory): http://www.njconsumeraffairs.gov/Pages/verification.aspx
- N.J. Department of Health licensure database (mandatory): http://www.state.nj.us/health/guide/find-select-provider/
- Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp
- 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

Third Party Liability

N.J.A.C 10:49-7.3

- Third Party Liability exists 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 of Third Party Liability (TPL) are Medicare, commercial health insurance and 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 (NJAC 10:49-7.3).

Medicaid Fraud Control Unit (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud Prosecutor (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

The MFCU investigates and prosecutes alleged criminal actions:

- Allegations of physical abuse to beneficiaries
- Healthcare Providers who are suspected of defrauding the Medicaid Program
- Fraudulent activities by providers against the Medicaid
- 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

Bottom line:

Ignorance of the law excuses no one.

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

Questions? Please contact us!

Division of Medical Assistance and Health Services:

Website: https://www.state.nj.us/humanservices/dmahs/home/index.html

Medicaid Fraud Division

Email: provider-education@osc.nj.gov

Website: https://nj.gov/comptroller/about/work/medicaid/

Medicaid Fraud Control Unit

Email: NJMFCU@njdcj.org

Website: https://www.nj.gov/oag/medicaidfraud/

DMHAS Call Line Numbers

- NJ Mental Health Cares (1-866-202-HELP) for mental health support. Includes access to NJ Hope and Healing. 8am – 8pm, 7 days a week

- NJ Suicide Prevention Hopeline (1-855-654-6735). 24/7

- ReachNJ for access to substance use disorder treatment (1-844-REACHNJ). 24/7

- Helpline for the Deaf and Hard of Hearing (973-870-0677) VP for mental health support. 9am – 5pm, Mon – Fri.

Fraud Hotlines

Name	Contact Number/Email
Aetna Better Health of New Jersey	(855) 282-8272
Amerigroup New Jersey, Inc.	(866) 847-8247
Horizon NJ Health	(877) 378-5292
Liberty Dental Plan	(888) 704-9833 / Compliancehotline@libertydentalplan.com
NJ Medicaid Fraud Control Unit	(609) 292-1272 / NJMFCU@njdcj.org
NJ Medicaid Fraud Division	(888) 937-2835
UnitedHealthcare Community Plan	(844) 359-7736 / https://www.uhc.com/fraud
WellCare Health Plans of NJ, Inc.	(866) 678-8355

Third Party Liability

Name	Contact Number
TPL Hotline	609-826-4702
TPL Hotline en Español	609-777-2753

How did we do?

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

Questions?

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

provider-education@osc.nj.gov

Thank you!