Medicaid and Managed Care Presentation

Durable Medical Equipment

Useful Tools for a Compliant Medicaid Practice
December 15, 2016

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Goals For Today

To help you better understand:

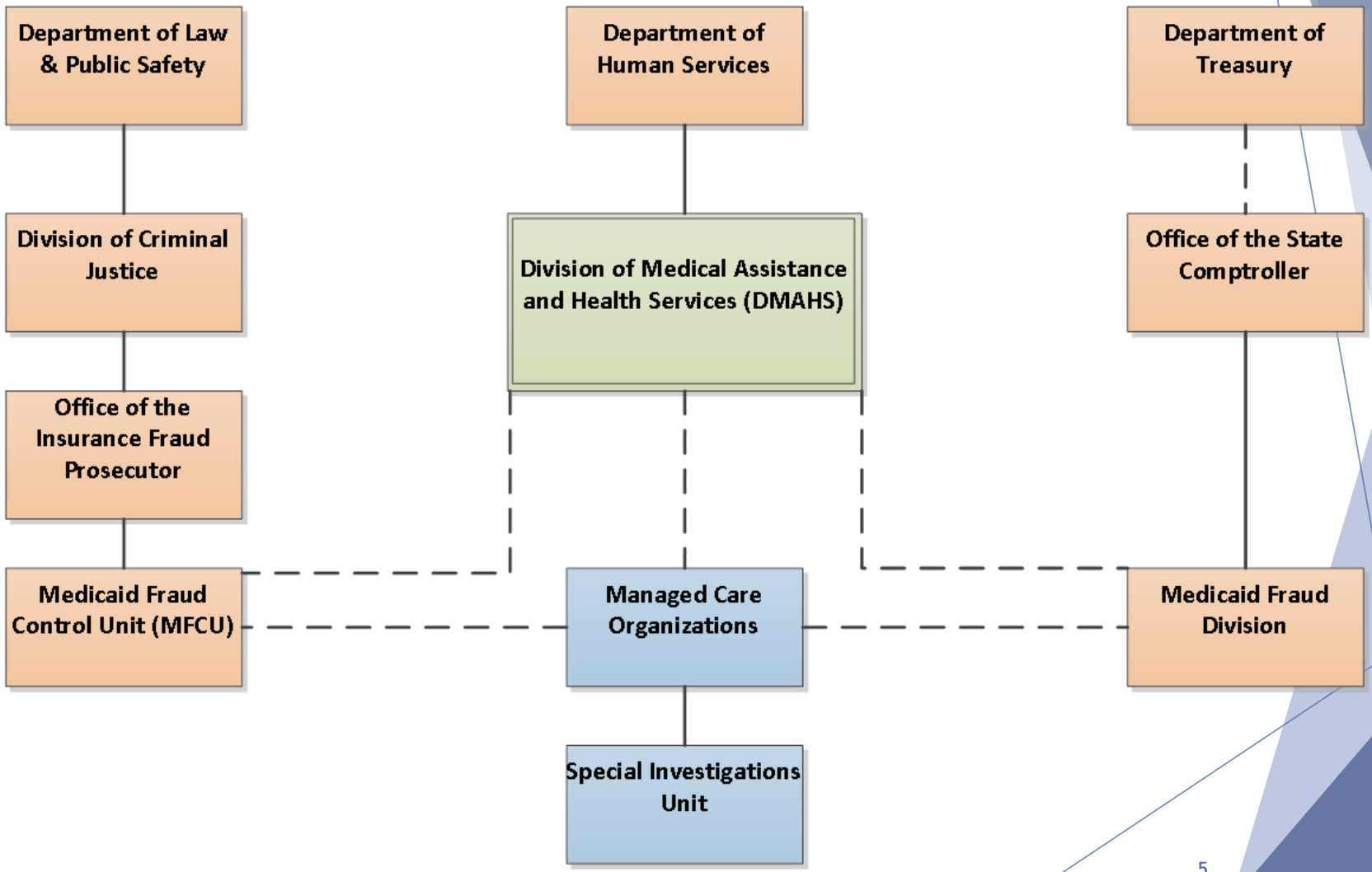
- The State agency and MCO structure
- The Medicaid regulatory framework
- Medicaid documentation requirements
- Third Party Liability (TPL) requirements
- Fraud, waste and abuse obligations
- Consequences for non-compliance
- Your obligations as a DME provider

What is Medicaid?

- Medicaid is a joint Federal and State program that helps pay medical costs if individuals have limited income and resources or meet other requirements.

- Medicaid is a voluntary program. If you want to participate, you must know, accept and abide by the rules and regulations.

Administration & Oversight



Medicaid Managed Care Contract

The New Jersey Department of Human Services, 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.

Durable Medical Equipment (DME)

§ 10:59-1.2 Definitions

"Durable medical equipment" (**DME**) as defined for this subchapter, means 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 of the following characteristics:

1. Is primarily and customarily prescribed to serve a medical purpose and is medically necessary for the beneficiary for whom requested;

2. Is generally not useful to a beneficiary in the absence of a disease, illness, injury, or disability; and

3. Is capable of withstanding repeated use (durable) and is nonexpendable; for example, hospital bed, oxygen equipment, wheelchair, walker, suction equipment, and the like.

Medical Supplies (MS)

§ 10:59-1.2 Definitions

"Medical supplies" means item(s) which are:

1. Consumable, expendable, disposable or non-durable;

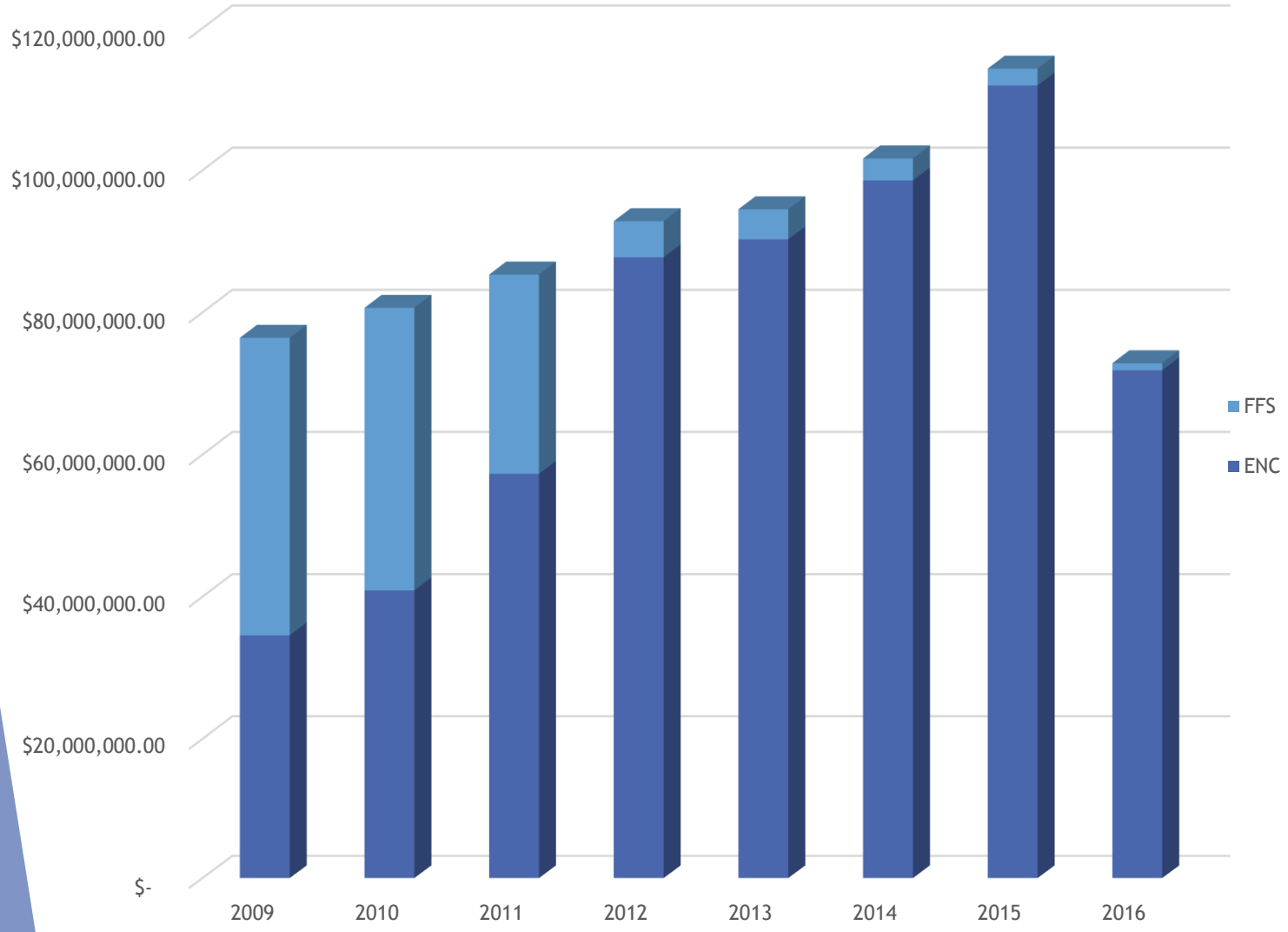
2. Prescribed by a practitioner; and

3. Medically necessary for use by an eligible beneficiary.

How are DME, MS claims categorized?

Claim Source	Fee-For-Service (FFS)	Encounter (ENC)
Category of Service	Medical Supplies: • 30 DME: • 31	Medical Supplies: • MSB (Pharmacy), • MSH (Home Health), • MSO (Outpatient, Not ER), • MSR (MS) DME: • MEB (Pharmacy), • MEH (Home Health), • MEO (Outpatient, Not ER), • MEQ (DME)
Provider Type	40	

Medicaid Exposure for DME, Medical Supplies



2009 to 2011 average

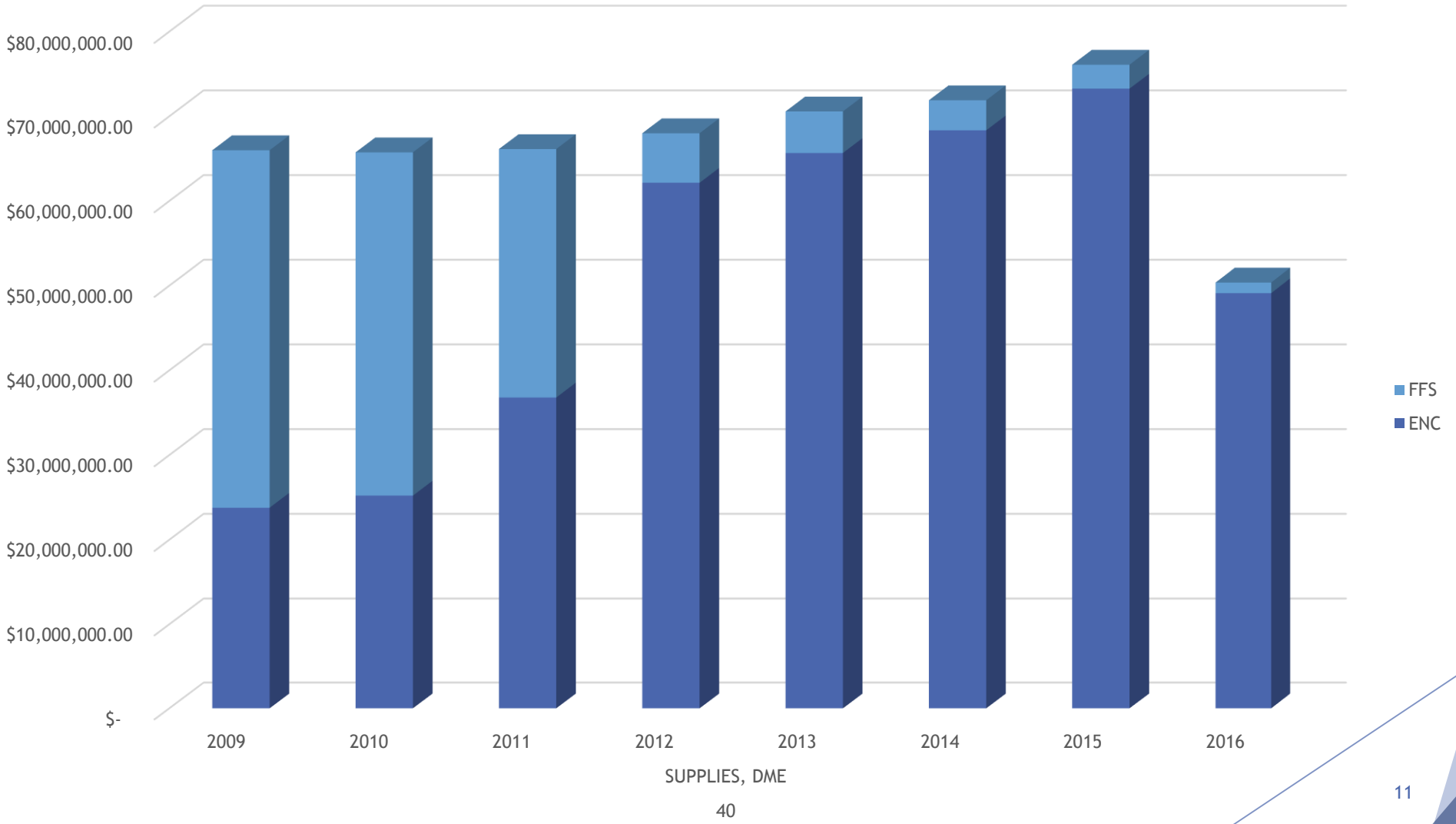
- $80.8 million per year

2012 to 2015 average

- $100.8 million per year

2016 – Jan. to Oct.

Medicaid Exposure by Provider Type



Fraud, Waste and Abuse

Meghan Ellerman

MCO Program Specific Requirements

- **Each MCO may have its own unique requirements:**
  - ✓ Medical policies
  - ✓ Prior authorization
  - ✓ Reimbursement policies
  - ✓ Claims submission process

- **When in doubt, consult your MCO-specific resources:**
  - ✓ Provider contract
  - ✓ Provider manual
  - ✓ Provider portal
  - ✓ Provider representative
  - ✓ MCO website
  - ✓ Newsletters and provider alerts

It is your responsibility to know these requirements.

Fraud

Fraud - 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.

- ***N.J. Stat. § 30:4D-55***

Waste

Waste is not defined in the rules, but is generally understood to encompass overutilization, underutilization or misuse of resources.

Waste is not usually a criminal or intentional act.

CMS's Fraud, Waste and Abuse Toolkit
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf

Abuse

Abuse - provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to Medicaid or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

The term also includes recipient practices that result in unnecessary costs to Medicaid.

- ***N.J. Stat. § 30:4D-55***

Third Party Liability

Christine Cheetham
Medicaid Fraud Division

Third Party Liability

…exists when any party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid or NJ Family Care program.

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

Third Party Liability

Medicaid and NJ Family Care (NJFC) benefits are **last** payment benefits. All Third Party Liability (TPL) must be used first and to the fullest extent in meeting the costs of the medical needs of a beneficiary.

A TPL's potential liability to pay for services **cannot** prevent a Medicaid beneficiary from receiving covered services.

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

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

1. For services, goods or supplies not covered or authorized by the NJ Medical Assistance and Health Services Act or by the Division of Medical Assistance and Health Services…

AND if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

AND if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

AND the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

N.J.A.C 10:74-8.7

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

2. The provider does not participate in Medicaid and NJFC either generally or for that service…

AND if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

AND if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

AND the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

N.J.A.C. 10:74-8.7

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

3. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider.

4 . For NJFC Plan C enrollee's contribution to care responsibility and for NJFC Plan D enrollee's required copayment.

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

10 Minute Break? Keep going?

DME Documentation Guidelines

Veronica Scott

DME Documentation Requirements

- Prior authorization, if applicable
- Physician Order
- Certificate of Medical Necessity from prescribing provider
- Proof of delivery

Physician Documentation Requirements

- Medical records – The recipient must have had a face-to-face visit with provider 6 months prior to DME physician order for DME.

- The face-to-face examination - must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

- Prior Authorization - if Applicable for certain DME supplies.

Physician Documentation Requirements

Written order– written order for the DME must not be prior to the face-to-face encounter. Encounter must document the recipient was treated for the issue related to the DME equipment it recommended. Written order must include the following at a minimum:

- Physicians name
- Item of DME ordered
- Prescribing provider's NPI
- Signature of the ordering practitioner
- Date of the physician order
- Certificate of Medical Necessity (CMN)

Supplier Documentation Requirements New Jersey Medicaid Supplier Manual

§ 10:59-1.5 Policy for providing medical supplies for DME.

- (a) Medical supplies and equipment require a legible, dated prescription or a Certificate of Medical Necessity (CMN) personally signed by the prescribing practitioner. Either document shall contain the following information:

- The beneficiary's name, address and Medicaid/NJ FamilyCare eligibility identification number; and

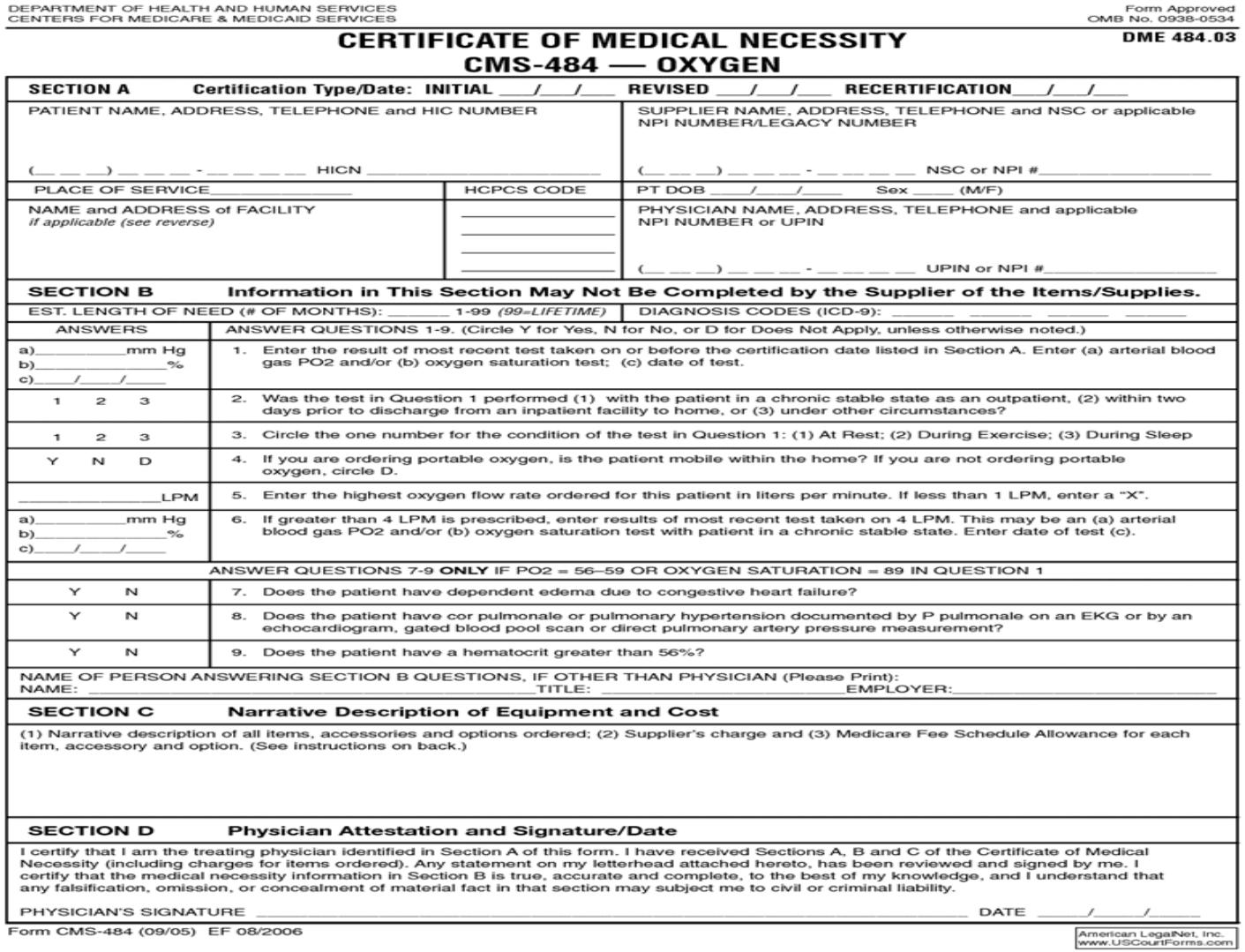
- A description of the specific supplies and/or equipment prescribed;

  For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair. The order shall describe the type and style of the wheelchair.

Supplier Documentation Requirements New Jersey Medicaid Supplier Manual

- The length of time the medical equipment items or supplies are required;
- A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and
- The prescriber's name, address and signature.
  - (b) Other information in addition to (a) above may be required for specific items and services, and is described in other sections of this chapter which are related to coverage of the specific item or service.
  - (c) The documentation required in (a) and (b) above shall be maintained on file for a minimum of five years from the date the service was rendered.

Certificate of Medical Necessity



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY
CMS-484 — OXYGEN

DME 484.03

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE_____	HCPCS CODE	PT DOB ____/____/____ Sex _____ (M/F)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 *(99=LIFETIME)* | DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)____/____/____	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
1 2 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X".
a)_____mm Hg b)_____% c)____/____/____	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
	ANSWER QUESTIONS 7-9 **ONLY** IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER:_____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____

Form CMS-484 (09/05) EF 08/2006

American LegalNet, Inc.
www.USCourtForms.com

Certificate of Medical Necessity

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY — **DMERC 01.02A**

HOSPITAL BEDS

SECTION A — **Certification Type Date:** INITIAL __/__/____ REVISED __/__/____

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

(___)___-____ HICN _____

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(___)___-____ NSC # _____

PLACE OF SERVICE _____
NAME and ADDRESS of FACILITY if applicable (See reverse

HCPCS CODE
_____
_____
_____
_____

PT DOB __/__/____ Sex ____ (M-F) | HT. _____ (in.) | WT. _____ (lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: _____
PHYSICIAN'S TELEPHONE #: (___)___-____

SECTION B — **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.
Y N D	1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C — **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D — **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE __/__/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS-847 (0498)

DME Risk Category: HIGH

- The MFD and DMAHS assigned DME to the high risk category
- High Dollars Spent
- High Risk for Fraud, Waste and Abuse

Red Flags

Mathew Lawrie, AHFI
Horizon NJ Health

Red Flags

- High Quantity/High Frequency on orders
- Billing for more expensive items such as customized wheelchairs or custom shoe inserts than were provided
- No proof of delivery on auto shipments
- Billing beyond the rental period
- Rentals that exceed the purchase price of the item
- Circumventing an MCO's preauthorization process by billing below the dollar threshold
- Use of DME miscellaneous codes
- Phantom DME suppliers

Red Flags

- Recruiting physicians to act as prescribing physicians
- Offers of free equipment or services to members in exchange for their insurance information.

Medicaid Fraud Division Audits & Investigations

Review Period

N.J. Stat. § 2A:14-1.2 (2016)

- 10 year statute of limitation
- MFD has the capability to review records as far back as 2006

N.J. Stat. § 30:4D-12 (2016)

- Records must be retained for at least 5 years from the date the service was rendered
- Records must include:
  - Name of the recipient
  - Date of service
  - Nature and extent of each service
  - Any additional information that may be required by regulation

Medicaid Fraud Division Audits & Investigations

Relevant Statutes

N.J.A.C. 10:49-9.8 (2016)

- All providers shall certify that the information furnished on the claims is true, accurate, and complete.
- Providers must keep such records as are necessary to disclose fully the extent of services provided
    - Ex. Invoices serve as one form of proof that you purchased and supplied a Medicaid beneficiary with DME or Medical Supplies
- All employees, contractors, or subcontractors shall meet all the requirements of the Medicaid or NJ FamilyCare programs
- Must ensure all individuals or entities have current/ valid licenses and certifications (also includes equipment and vehicles)

Medicaid Fraud Division Audits & Investigations

Relevant Statutes Continued

N.J.A.C. 10:49-5.5 (2016)

- Services not covered by Medicaid if
  - No medical necessity
  - No prior authorization
  - Records inadequate and illegible
  - Prescribing Physician excluded from participation in Medicaid

NOTE: This is not the complete list of non-covered services. The full list consists of 18 items and can be found in the Administrative Code section listed above.

Consequences

Lt. Joseph Jaruszewski
609-633-2228

Lt. Louis Renshaw
973-599-5954

Medicaid Insurance Fraud is a Serious Crime

- The MFCU in the Office of the Insurance Fraud Prosecutor (OIFP) investigates and prosecutes Medicaid Fraud.
- The MFCU utilizes Attorneys, Investigators, Nurses, Auditors and other support staff to police the Medicaid system.

Medicaid Fraud (*N.J.S.A.* 30:4D-17)

- It is illegal to knowingly and willfully make or cause to be made any false statement in a claim.
- It is illegal to over bill Medicaid for services provided or services that were not received.
- It is illegal to participate in a scheme to offer or receive kickbacks or bribes in connection with the furnishing of items or services that are billable to Medicaid.

Medicaid Fraud Consequences

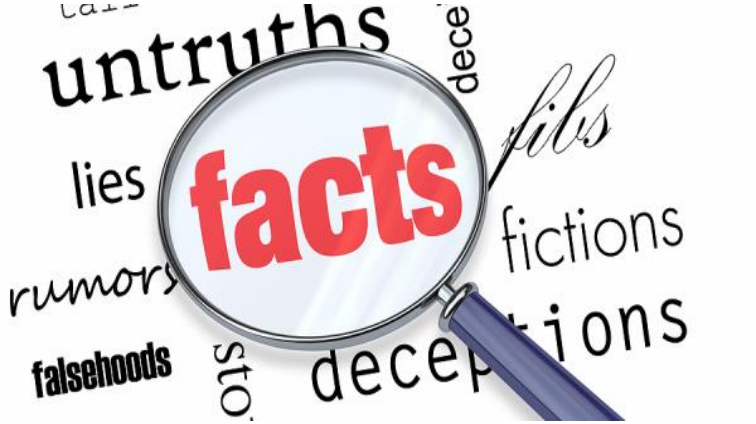
- Punishable by up to 5 years in state prison
- Mandatory penalty up to $25,000 for each violation
- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Restitution/Recovery of overpayments

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

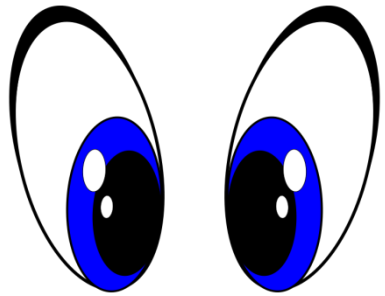
Did you know…

- 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.



Whistleblower/Qui Tam

- Empowers people to file civil suit against individuals and companies that defraud the federal, state or local government.
- A person filing suit might be eligible for up to a 30 percent share of the recovery.
- A person filing suit might be protected from being fired or retaliated against by their employer for reporting fraud and abuse to authorities.



Sample Cases

True Crime

- Comfort Health
  - Submitted claims for non-orthopedic shoes and fake invoices to substantiate false claims
  - Two owners each sentenced to 3 years in State Prison
  - Ordered to pay $150,000 in restitution and a $150,000 penalty
  - Debarred from Medicaid

False Claims Act

- CareFusion
  - Settled a False Claims Act case alleging that CareFusion used unlawful marketing practices and paid illegal kickbacks to promote the use of surgical preparation solution Chloraprep
  - $40 million settlement paid to the Federal Government and various States
  - Whistleblower paid approximately $3.26 million as part of the settlement.

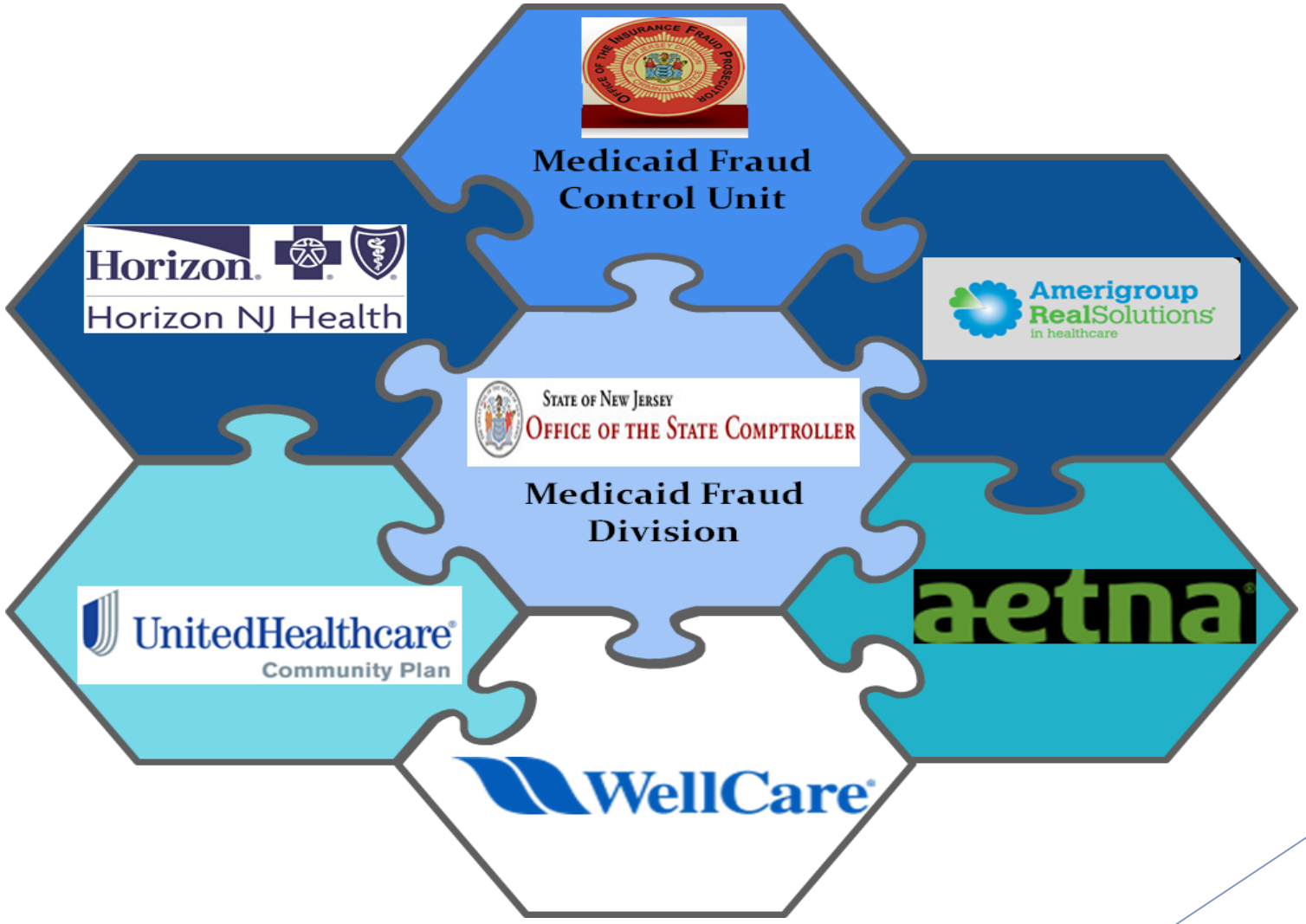
“Ignorance of the law excuses no one.”

Conclusion

Josh Lichtblau

Medicaid Fraud Division

MFD Brings us Together Regularly to Discuss FW&A Issues



Affordable Care Act

- 42 CFR §455.450 contains the screening requirements for providers who wish to enroll in the Medicaid program

Debarred Providers

- A debarred 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

Self-Disclosure

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments.

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

- Failure to return an overpayment makes you liable to the imposition of penalties of $5,500 to $11,000 per claim

Self-Disclosure

- MFD's self-disclosure policy is more liberal than OIG's policy
- If MFD agrees with your analysis, we do not impose interest or penalties
- MFD's Self-Disclosure policy can be found on our website, www.nj.gov/comptroller/divisions/medicaid/disclosure

MCO/MFD Recovery Actions

- Once an overpayment has been identified as a result of an investigation, actions to initiate recoupment of the funds will take place
  - MCO will send a letter to the provider with the overpayment amount
  - MFD will send a Notice of Estimated Overpayment or Notice of Intent and, if necessary, a Notice of Claim
  - MFD may add false claim penalties between $5,500 and $11,000

What You Learned Today

- All of the state agencies and MCOs that have oversight of your contracts and billing
- What the Medicaid Regulatory Framework looks like
- How the Medicaid requirements apply to you
- Your obligation to comply with rules and regulations for documentation and billing in order to avoid allegations of fraud, waste and abuse
- What can happen to you if you are not compliant

Who to Contact

Do You Suspect NJ Medicaid Fraud, Waste or Abuse?

Contact the corresponding fraud hotline:

Fraud Hotline Numbers

Aetna Better Health of New Jersey	1-855-282-8272
Amerigroup	1-877-725-2702
Horizon NJ Health	1-855-FRAUD20
UnitedHealthcare	1-800-941-4647
WellCare Health Plans of NJ, Inc.	1-866-678-8355
Medicaid Fraud Division	1-888-937-2835
Medicaid Fraud Control Unit	1-609-292-1272

Speak up - you can make a difference!

Questions

- Thank you for attending!
- Your opinion matters. Please complete your evaluation form before you leave.