Annual Report
Fiscal Year 2018

Arkansas Office of the Medicaid Inspector General

Message from the Medicaid Inspector General

I am pleased to present the Medicaid Inspector General's annual report for Fiscal Year 2018 to Governor Asa Hutchinson, Attorney General Leslie Rutledge, the Legislature and the citizens of Arkansas.

The Office of the Medicaid Inspector General (OMIG) continues to make great strides year after year. OMIG identified $4,733,944.81 for recovery in Fiscal Year 2018, which is a 24.9 percent increase from Fiscal Year 2017. In the last five years, OMIG has identified nearly $16.4 million in claims. This report details our activities and initiatives, as required by Ark. Code Ann. §20-77-2509.

OMIG is charged with recommending changes to Medicaid policy to improve integrity in our program as well as identify savings. Some highlights for the Fiscal Year include OMIG's support for the transition to a managed care program for dental services as well as a comprehensive review of personal care services.

In its second year, the OMIG Provider Awareness Letter (PAL) initiative continues to be a successful program and shows significant return on investment. Additionally, this initiative has brought national attention to Arkansas for innovation in program integrity practices. Our PALs have reached more providers than the traditional audit model and are a mechanism for outreach and education on best practices to Arkansas Medicaid providers. The PAL initiative has been an instrumental and efficient communication tool for OMIG to cultivate positive relationships with providers, promoting overall improvement of the Arkansas Medicaid program.

Looking ahead to 2019, OMIG will continue its mission to work closely with Medicaid, DHS, and other local, state, and federal entities to protect and ensure that all state and federal dollars are being spent appropriately to provide necessary treatment and services to Arkansas Medicaid recipients. Fostering positive relationships with Medicaid providers remains a central theme in this office.

Respectfully,

Elizabeth Thomas Smith

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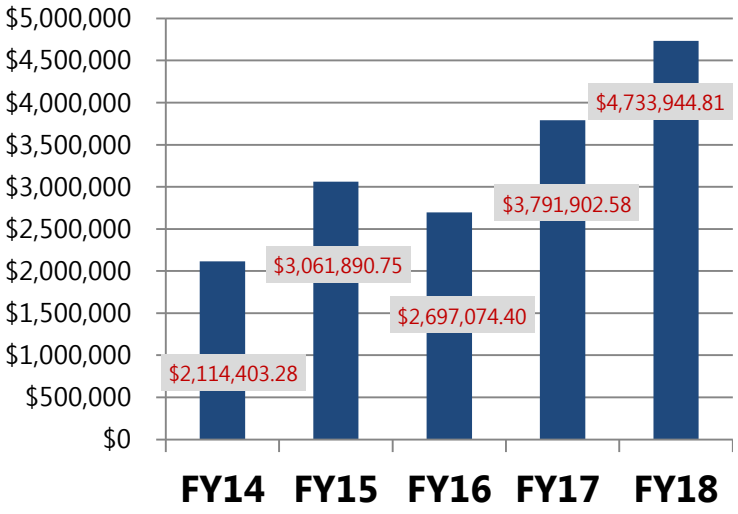
Summary

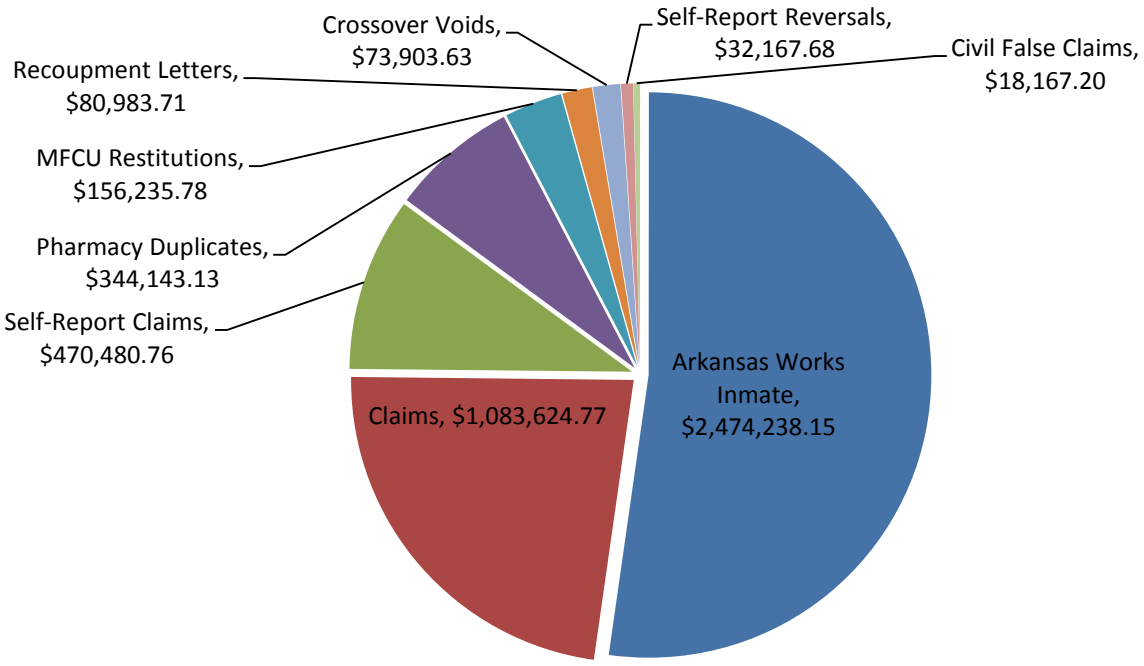
OMIG Recoveries and Recoupments

The total amount of Medicaid funds identified for recoupment and recovery in Fiscal Year 2018 by OMIG audits and reviews is $4,733.944.81, which is a 24.9% increase from last fiscal year. The increase this year can be attributed to OMIG's ability to more accurately identify issues through use of analytic tools and an increase in provider reviews and contacts. The Provider Awareness Letter initiative resulted in increased self-reports. A large portion of the improper payments identified is a result of OMIG's review of Arkansas Works recipient eligibility.

Five-year Analysis of OMIG Identified Claims



Fiscal Year 2018
Total Claims Identified: $4,733,944.81



Summary

In Fiscal Year 2018, $2,098,149.58 was collected as a result of audits and initiatives from this and prior fiscal years. OMIG claims, collections, and reversals include settlement checks, recoupments of overpayments, provider self-reported payments and reversals of improper claims, along with claims voided as a result of being paid by both Medicare and Medicaid "crossover claims" when, as payer of last resort, Medicaid should not have paid. Recoupment and reversal of claims occurs through the Medicaid payment system and is often spread over several months spanning fiscal years. A majority of dollars recovered were a result of collections through DHS claims adjustments. Claims adjustments are posted when claims are resubmitted due to prior denials or voids.

OMIG Recovery and Recoupment

DHS Adjustments	$1,375,968.83
Self-Report Collections	$445,013.12
Crossover Claims Reversals	$183,889.04
Restitution and False Claims	$61,110.91
Self-Report Reversals	$32,167.68
TOTAL	**$2,098,149.58**

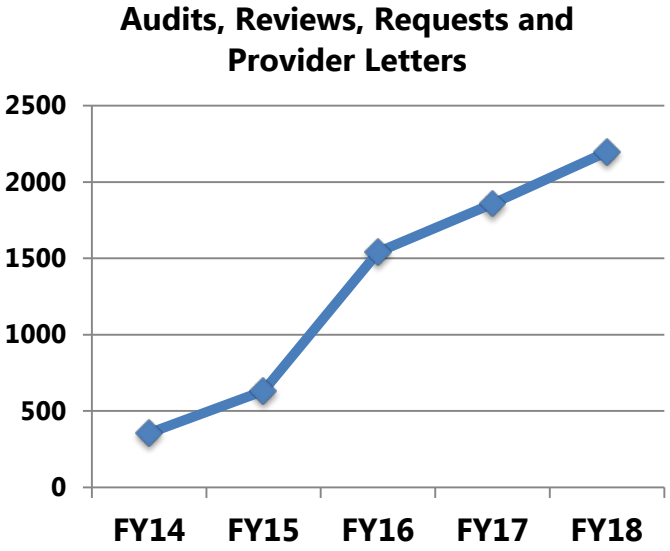
Summary

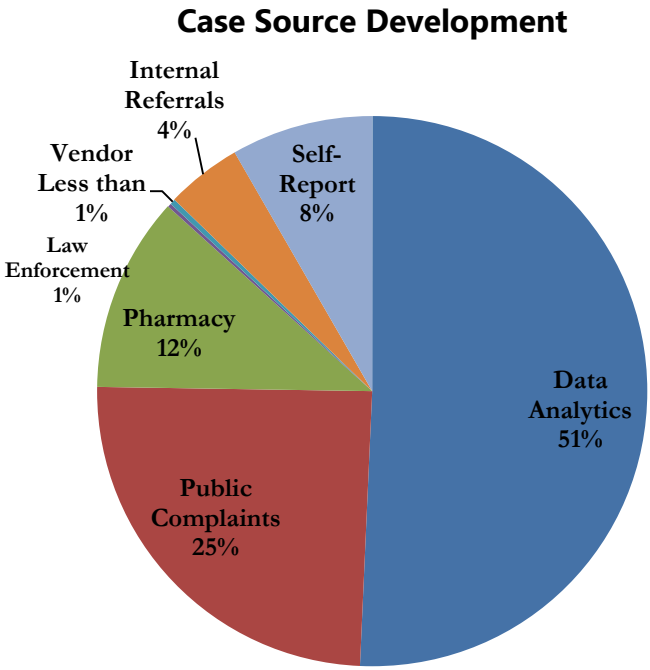
OMIG Audit Activities

OMIG's audit activity is multi-faceted. OMIG staff initiates either onsite or desk audits to review medical records for Arkansas Medicaid providers. OMIG uses professionally trained auditors, coders, and medical professionals to review these records for fiscal integrity. Providers also perform "self-audits" which are forwarded to OMIG for independent, objective review. Reports of potential violation of the Arkansas or federal False Claims Act (FCA) are investigated through a compliance review process. Increasingly, OMIG uses data analysis to detect potential practices of fraud, waste or abuse, and initiates recoupment or recovery letters seeking return of funds or clarification of information for detected incidents and patterns of fraud, waste or abuse. In Fiscal Year 2018, the number of onsite audits, desk audits, provider self-audits, FCA Compliance Reviews, and recoupment letters totaled 2,198 separate events or cases, broken down in the following charts.

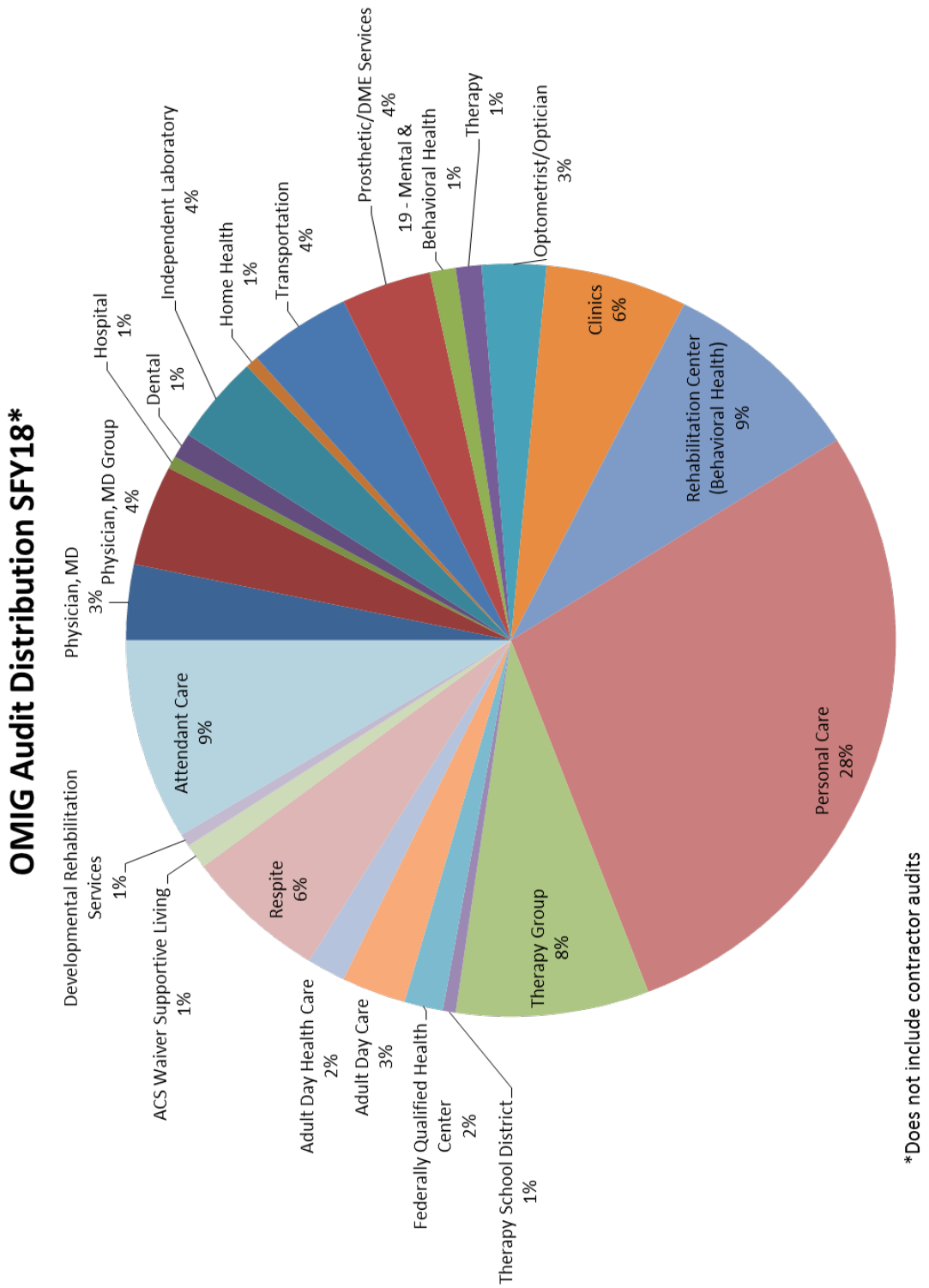
Summary of Audit Activities

Onsite Audits	47
Desk Audits	138
Provider Self Audits	553
False Claims Act Reviews	132
Recoupment Letters	1,141
Contractor Audits	187
TOTAL	**2,198**





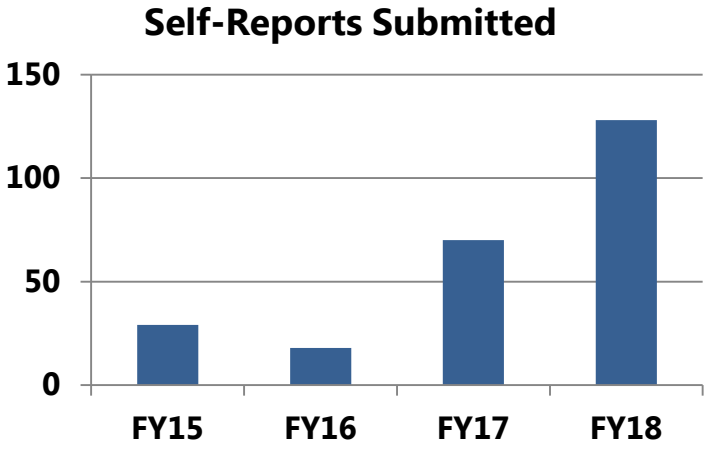
Summary

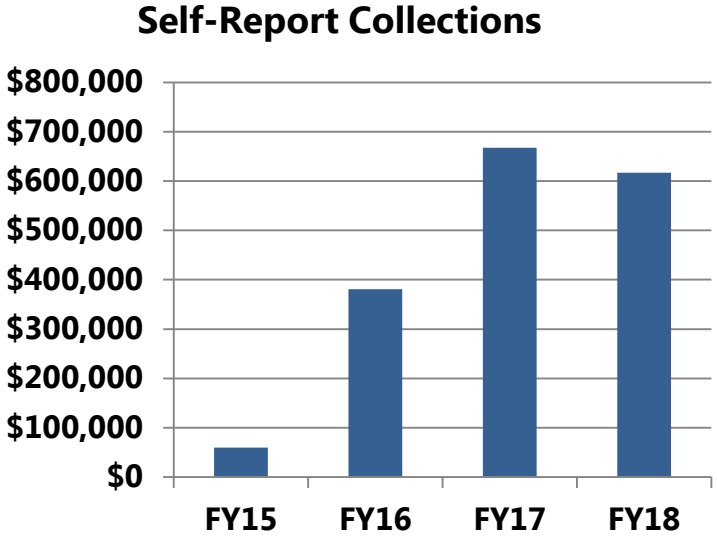

OMIG Audit Distribution SFY18*
Physician, MD 3%
Physician, MD Group 4%
Hospital 1%
Dental 1%
Independent Laboratory 4%
Home Health 1%
Transportation 4%
Prosthetic/DME Services 4%
19 - Mental & Behavioral Health 1%
Therapy 1%
Optometrist/Optician 3%
Clinics 6%
Rehabilitation Center (Behavioral Health) 9%
Personal Care 28%
Therapy Group 8%
Therapy School District 1%
Federally Qualified Health Center 2%
Adult Day Care 3%
Adult Day Health Care 2%
Respite 6%
ACS Waiver Supportive Living 1%
Developmental Rehabilitation Services 1%
Attendant Care 9%
*Does not include contractor audits

Summary

Medicaid Provider Self-Reports

In Fiscal Year 2018, 128 Arkansas Medicaid providers disclosed to OMIG a total of $616,992.64 in improper payments received in error from the Arkansas Medicaid program. Of that amount, $397,211.80 – approximately 64 percent – was reported in response to letters sent to providers pursuant to the Provider Awareness Letters (PALs) initiative, while the remainder was comprised of independent reports from providers. OMIG's self-report procedure enhances elimination of fraud, waste, and abuse, while decreasing provider burden by offering Medicaid providers a mechanism to reduce their legal and financial exposure. Providers who are self-reporting must submit a Corrective Action Plan (CAP) including appropriate measures to prevent recurrence of identified issues.





Administrative Actions

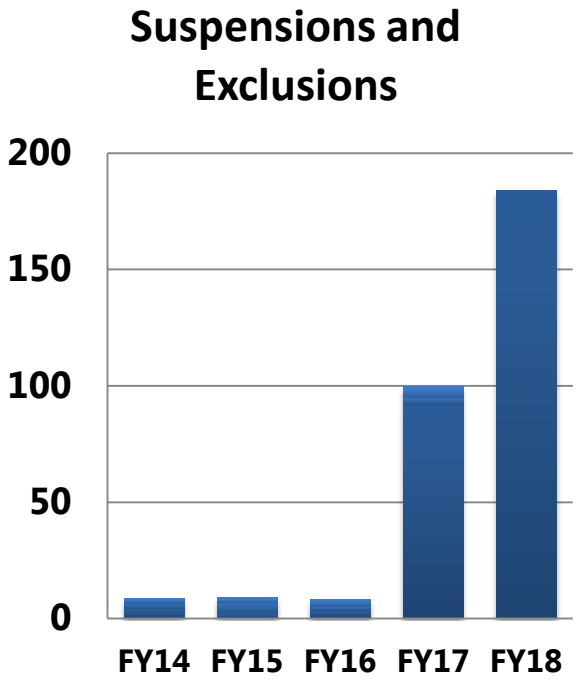
Suspensions and Exclusions

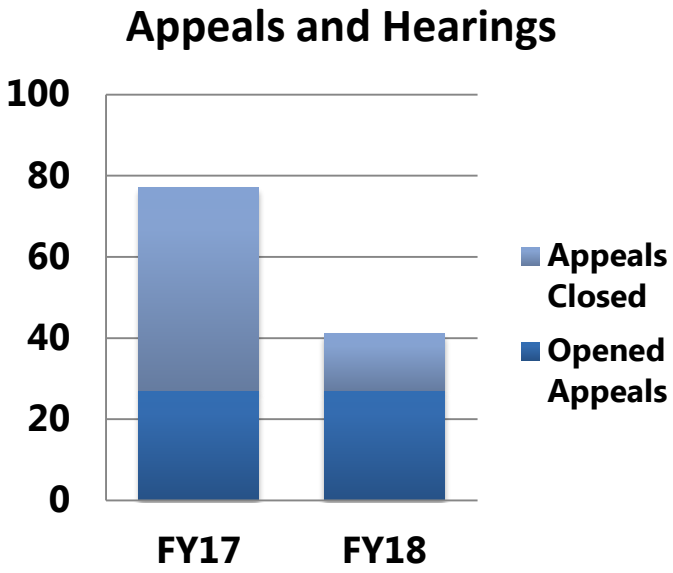
OMIG pursues civil and administrative actions against individuals and entities engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension or exclusion from the Medicaid program.

Provider suspensions	113
Provider exclusions	71
2018 Total	**184**

Appeals and Hearings

Providers have the right to appeal OMIG audit findings and administrative actions. In Fiscal Year 2018, 27 appeals were filed. Eighteen appeals were closed by negotiated settlement, some of which had been initiated in prior fiscal years. Recoveries not received at settlement or at the close of hearing, are recouped from future Medicaid payments.





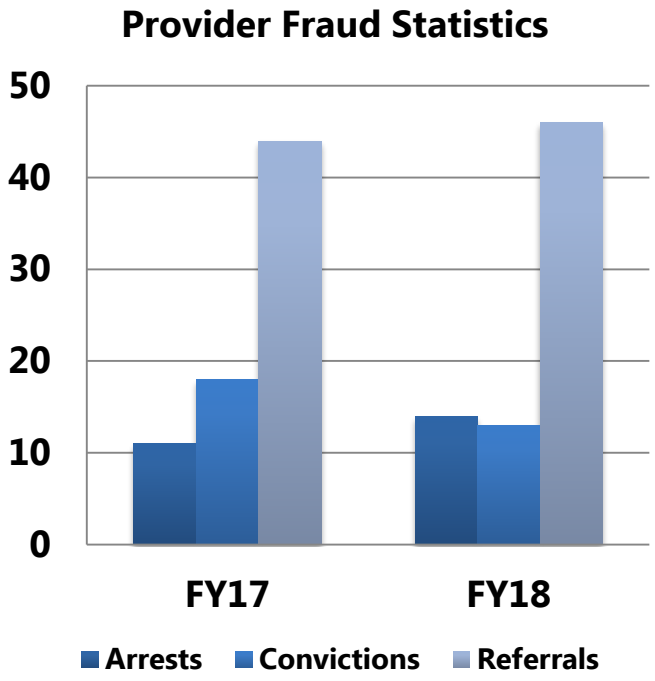
Administrative Actions

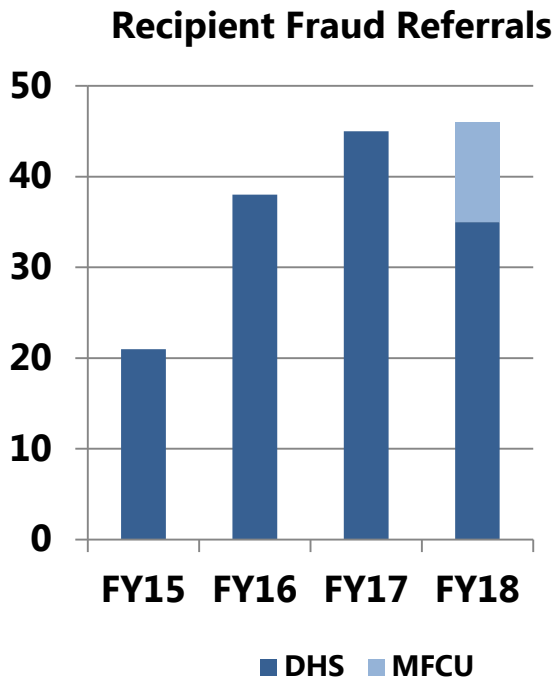
Provider Fraud

Fraud investigations and referrals are handled by OMIG's Medicaid Fraud Investigator who serves as the agency liaison to the Attorney General's Medicaid Fraud Control Unit (MFCU). In Fiscal Year 2018, 120 cases were opened for investigation, 46 of which were referred to MFCU for fraud. OMIG's fraud investigations originate from public complaints received through the OMIG fraud hotline, website, data analytics, self-reports, audits, agency referrals, and law enforcement referrals. OMIG's increased use of and reliance on data analytics is consistent with national and federal program integrity trends and proves to produce more effective and efficient investigations.

Recipient Fraud

In Fiscal Year 2018, OMIG referred 35 cases of suspected recipient fraud to the DHS Fraud Unit. The DHS Fraud Unit reviews these cases for determination of recipient eligibility and refers fraud cases to local prosecutors. Cases involving collusion between Medicaid recipients and Medicaid providers are investigated by the Attorney General's Medicaid Fraud Control Unit. This year, OMIG identified and referred 11 cases of recipient fraud in connection with Medicaid provider fraud to the AG MFCU. The increase is due to OMIG's extensive work reviewing Personal Care services.





Initiatives

Program and Policy Review

Arkansas Works Recipient Eligibility Review

Section 1905(a)(29)(A) of the Social Security Act specifically excludes medical assistance payments for individuals who are inmates of a public institution. The Arkansas Medicaid program is obligated to recoup improper payments made in violation of federal law. OMIG began an initiative to determine whether Arkansas Works Premium payments were being made on behalf of incarcerated persons. The Arkansas Department of Correction worked closely with OMIG to provide inmate information for OMIG to compare with Arkansas Medicaid Recipient enrollment files. OMIG data analysis matched the inmate data with enrollment data and identified that Arkansas Works premium payments were being paid on behalf of incarcerated recipients. In September 2017, Inspector General Smith reported this finding immediately to DHS in an effort to return improper payments made in October of 2017, and to avoid future improper premium payments. OMIG continued review the matched recipients to determine whether other premiums were improper. Due to the nature of the inmate population being released and re-incarcerated, this was a complex process. In February 2018, OMIG notified DHS a total of $2,474,238.15 had been paid in Arkansas Works premiums during 2017 for recipients incarcerated in the ADC. OMIG requested DHS recover these payments and requested a corrective action plan to prevent future improper payments. OMIG worked closely with DHS and ADC to create a functional streamlined process to identify the incarcerated recipients to avoid improper payments going forward, and to calculate the exposure to the program. OMIG continues ongoing oversight and analysis of the inmate population. Data regarding other inmate populations (not in the ADC) is not readily available, so OMIG has partnered with DHS, DIS and the National Governor's Association to identify a solution to obtain this necessary data.

Comprehensive Personal Care Services Program Review

The Centers for Medicare and Medicaid Services (CMS) conducts reviews of each state's program integrity activities on a periodic basis to provide oversight of Medicaid program integrity. CMS program integrity reviews are currently focused on each state's oversight of personal care services (PCS), which are comprised of: Personal Care, ARChoices Waiver, Self-Directed Services, and Home Health. CMS has made PCS a focus due to the inherent

vulnerabilities associated with this program and its recipients. OMIG's oversight of PCS services, along with the state Medicaid agency, was reviewed by CMS in March 2018 for federal Fiscal Year 2015-2017. During this time, OMIG significantly increased its review of PCS with more provider audits being conducted for those services than any other program. As a result, PCS has also been the leading issue for OMIG fraud investigations with 85 fraud referrals being made to the AG's MFCU during the review period. In addition to provider audits, OMIG's concentration extends to education and training. OMIG has sent provider awareness letters to PCS providers to provide education on proper billing, and has partnered with DHS, AFMC, and provider associations to conduct training sessions for PCS providers. Further, OMIG presented on attacking vulnerabilities in PCS at the annual conference for the National Association for Medicaid Program Integrity in August of 2018. OMIG anticipates that its oversight capabilities will be increased upon DHS implementation of electronic visit verification and assignment of identification numbers to all PCS aides in 2019. The assignment of identification numbers, which was recommended by OMIG to DHS in August 2016, is a critical component to providing adequate oversight of PCS services. OMIG's recommendation is similar to CMS' draft report that emphasizes the need for an identification number for PCA aides.

Electronic Visit Verification

In December 2016, the United States Congress signed into law the 21st Century Cares Act (Public Law 114-255). This act was designed help hasten the discovery and delivery of new cures and treatments, and also mandated that state Medicaid agencies implement electronic visit verification (EVV) for all PCS and home health services requiring provider in-home visits. Federal regulations require EVV use for all Medicaid-funded PC services by January 1, 2020. Over the last few years, OMIG has been recommending that the Arkansas Medicaid program develop more stringent controls and regulations regarding the oversight of personal care and home health services. This recommendation included the identification of services performed by personal care aides and rendering providers. OMIG's recommendations were predicated on years of identifying fraud and improper billing by personal care providers. In the spring of 2017, The DHS Payment Integrity Unit and the Arkansas Office of State Procurement released a Request for Proposal (RFP). A management employee from OMIG served on the RFP evaluation committee. OMIG will assist in oversight of the contract deliverables. A robust EVV program can be used to regulate and prevent

improper billing and Medicaid fraud as well as to provide better services and assistance to Medicaid recipients.

Non-Sterile Gloves

In June of 2018, OMIG sent 166 courtesy letters to durable medical equipment/prosthetics providers to clarify the unit definition and reimbursement rate in the Arkansas Medicaid Provider Manual for non-sterile gloves (procedure code A4927). Additionally, OMIG recommended DHS review the Fee Schedule for reimbursement for procedure code A4927 and solicited valuable feedback from providers that would assist in the policy revision process.

As a result, the review resulted in a change in the reimbursement amount for procedure code A4927 to $5.22 per 100 gloves effective August 1, 2018. Based on billing volume for the previous fiscal year, this fee schedule change is projected to result in an estimated $1.45M for A4927. This equates to approximately a 65% reduction in cost for this procedure for the Arkansas Medicaid program.

Dental Managed Care

In 2017, Delta Dental of Arkansas and Managed Care of North America Dental entered into statewide contracts with DHS as dental benefits managers for the Arkansas Medicaid/CHIP program. OMIG seeks to bolster the transparency, accountability, and integrity of these Medicaid Managed Care Organizations (MCOs) by imposing and clarifying requirements meant to reduce fraud, waste, and abuse. In order to fulfill this objective, OMIG has created an Oversight Division (OD) responsible for regulating, convening with and analyzing reports from the MCOs to ensure they are operating in compliance with statutory and contractual requirements. The OD has required the MCOs to create and maintain Program Integrity Plans which must include dedicated staff members charged with monitoring, promptly responding to, investigating and correcting compliance issues. As part of this system, the plans must identify compliance officers, establish Special Investigations Units and Fraud Investigation and Review and Compliance/Risk Committees, implement analytical tools for FWA detection, identify provider audit methods, provide compliance education and training goals, and facilitate the submission of quarterly and yearly audit and progress reports and fraud referrals to OMIG.

Provider-led Arkansas Share Savings Entity (PASSE)

In the fall of 2017, OMIG began to work with the state Medicaid agency on the plans for Program Integrity for the

PASSE (Provider-led Arkansas Shared Savings Entity) program to ensure consistency with the Managed Care Final Rule of 2016.

As the PASSE model nears implementation, OMIG has attended the PASSE CEO meetings to answer questions and offer guidance for program integrity within their networks and will continue regular meetings with the PASSE CEOs and providers. OMIG's involvement in oversight is critical for compliance with state and federal regulation, the ensure savings, and as well as to identify and prevent fraud.

Opioids Review and Reform

OMIG joined the United States Attorney for the Eastern District of Arkansas and the Arkansas Attorney General's Medicaid Fraud Control Unit in creating an Opioid Task Force prior to the Department of Justice directives regarding the Opioid crisis. The Opioid Task Force is comprised of state and federal law enforcement agencies, state and federal agencies overseeing provision of health care, and fraud detection units of private insurance providers. The Opioid Task Force meets quarterly to collaborate on efforts to combat the Opioid crisis. OMIG Data Analytics team examined prescriber and dispensing practices by comparing multiple opioid prescriptions within Medicaid households, performing link analysis of high prescribers with recipients and pharmacies, and identification of excessive prescribing practices. Results of these reviews have been provided to the DEA for investigation. OMIG assisted in coordinating an effort among federal agents, the Arkansas Department of Health, the Department of Human Services, Pharmacy Board, Long Term Care Providers, and other stakeholders to ensure proper disposal of unused pharmaceutical controlled substances. OMIG currently serves on the PDO Advisory Workgroup of the Arkansas Alcohol and Drug Abuse Coordinating Council. The PDO, among other responsibilities, selected the High Needs Communities for 2016 SAMHSA grant funding to develop prescription-drug misuse prevention to reduce prescription drug and opioid overdose-related deaths; behavioral health disparities among racial and ethnic minorities; and implement a naloxone program. OMIG also works closely with the DHS pharmacy division in review of provider prescribing practices, policy review, and in sharing tools and techniques to assist in identifying issues related to opioid misuse.

Initiatives

Contractor Audits

In order to enhance program integrity, OMIG uses a DHS contractor, Optum, and a CMS contractor, Qlarant Integrity Solutions, to assist in performing program integrity functions.

Optum Pharmacy

Optum provides a licensed Arkansas pharmacist and pharmacy technician, to perform desk and onsite audits of selected pharmacies. In Fiscal Year 2018, 256 pharmacies were reviewed, 25 received an onsite audit, 161 received a desk audit, and 70 pharmacies received Provider Awareness Letters. A total of $58,402.53 was identified for recovery. Since this partnership began in FY15, $574,004.55 has been refunded to Arkansas Medicaid.

Recommendations for policy reform made by Optum and OMIG in 2016 continue to produce valuable savings. The "14-day reversal" policy requiring reversal of claims for pharmaceuticals not delivered within 14 days resulted in $286,633 savings in this year.

The Prospective Drug Utilization Early Refill (ER) edit which became effective in February 2016 continues to result in significant cost savings. The number of paid claims associated with an early refill for a maintenance medication decreased by 54% in Fiscal Year 2018 resulting in $1.19 million in cost avoidance. The average days' supply for all maintenance medications decreased from 31.95 days to 29.60 days resulting in approximately $73,000 in additional cost avoidance. Thus, an estimated $1.26 million dollars in total savings was related specifically to the reduction in excessive fills of maintenance medications for Fiscal Year 2018. Because provider billing behavior regarding ProDUR alerts has not changed since the ER hard edit was created, cost avoidance for Fiscal Year 2018 was determined based on information related to pre-edit claim submissions.

Optum Fraud and Abuse Detection System (FADS)

In addition to pharmacy audits, Optum hosts the Medicaid Enterprise Decision Support System that contains the Fraud and Abuse Detection System (FADS). This software system provides data extraction tools that OMIG uses to prevent and detect fraud, waste and abuse. The tools in FADS include:

- Case Tracking
- Peer Group Profiling
- Query and Report Writing
- Simple Browse and Search

Team members from Optum and OMIG continue to meet regularly to collaborate on analytics, studies, and potential leads pertinent to OMIG's

mission. Representatives from Optum have also conducted on-site FADS training to new and current users.

Medical Audit and Review Solutions (MARS)

Optum provides Medical Audit and Review Solutions (MARS) which uses analytic algorithms to identify and recommend cases to OMIG for review and audit. As a collective exchange, OMIG presents cases to MARS requiring physician review or review of medical necessity. A physician peer review process is led by licensed MARS specialty physicians to provide clear, unbiased, and evidence-based determinations. In Fiscal Year 2018, MARS performed 9 audits of behavioral health, personal care, and attendant and respite care providers.

Unified Program Integrity Contractor (UPIC)

CMS created the Unified Program Integrity Contractor (UPIC) to combine and integrate existing functions (formerly performed by Medicaid Program Integrity Contractors (MIC) and Zone Program Integrity Contractors (ZPIC)) into a single contractor defined by geographic area (UPIC Jurisdiction). The UPIC is contracted to perform Medicare and Medicaid program integrity reviews and assistance to state program integrity functions (like OMIG) on behalf of CMS. Arkansas lies within the Southwestern UPIC jurisdiction along with Colorado, Oklahoma, Mississippi, Missouri, New Mexico, and Texas.

Qlarant Integrity Solutions was awarded the UPIC contract for the Southwestern jurisdiction. OMIG has begun working with Qlarant to assist with detection of fraud, waste, and abuse.

Provider Awareness Letters (PALs)

OMIG has been recognized as a national leader in innovation for Program Integrity practices for its Provider Awareness Letter (PAL) initiative. OMIG is continually building upon and expanding its focus on provider outreach and education by developing strategies that create the greatest return on investment. OMIG initiatives have served as a mechanism to effectively correct behaviors across a wide range of provider groups and identify areas ripe for change in the Arkansas Medicaid program. Cost avoidance opportunities continue to develop while identifying cost-effective ways to maximize the use of agency resources to detect and combat fraud, waste, and abuse. OMIG expanded its provider awareness initiative for self-audit requests of providers for selected claims in Fiscal Year 2018. Rather than OMIG conducting full scale audit of these providers, the letters allowed OMIG to utilize fewer resources to reach more providers efficiently, creating a positive return on investment. OMIG used peer group profiling to analyze claims data to identify providers who deviated significantly from their peers for potentially aberrant billing behaviors. Based on this identification, Provider Awareness Letters (PALs) were sent to the outlier providers where OMIG requested review of the claims. If a provider identified any improper payments, OMIG asked that the provider return those funds and submit a corrective action plan (CAP) to correct the billing behavior.

The following provider awareness letters were submitted in Fiscal Year 2018:

- False Claims Act Compliance
- Personal Care ARChoices Authorization
- Federally Qualified Health Centers
- Locum Tenens Billing
- Multiple Eye Exams
- RSPMI CPT Procedure Codes 90885 and 90887

False Claims Act Compliance

OMIG completes False Claims Act Compliance Reviews after the close of the federal fiscal year per the requirements of the Arkansas Medicaid State Plan. This annual campaign ensures compliance with the Section 6032 of the Deficit Reduction Act, and the Social Security Act, Section 1902(a)(68) regarding education of false claims recovery to employees. OMIG conducted 136 total False Claims Act Compliance Reviews during Fiscal Year 2018.

Initiatives

Personal Care ARChoices Authorization

According to the Personal Care Medicaid Provider Manual section 212.320, recipients enrolled in the ARChoices waiver may receive Personal Care services (PCS), but only when authorized by the DAAS RN, and the provider name and specific number of hours authorized must be identified on the AR Choices Person-Centered Service Plan (PCSP). OMIG audits identified numerous instances in which personal care was billed for waiver clients when personal care was not authorized. In lieu of further audits, providers were asked to review a listing of specific personal care claims paid to their agency for services provided to ARChoices recipients from July 1, 2016-June 30, 2017. Additionally, OMIG asked providers to review the PCSPs for each beneficiary identified to ensure that all personal care services billed were correctly authorized, and to report and repay any improperly billed claims.

Federally Qualified Health Centers

A School-Based Health Center (SBHC) is a resource for health care professionals to provide needed medical services to school-aged children on a school campus. This allows the children to remain at school and reduces time away from school for transportation to and from appointments. SBHCs can be owned and operated by a Federally Qualified Health Center (FQHC) among other models of administration. In 2017, based on a complaint, OMIG investigated the relationship between FQHC and SBHCs operating in the SBHC setting. OMIG's review resulted in recommendations to the Arkansas Department of Education for tightening referral policies for SBHCs, a recommendation that a school nurse should be available on school campuses during school hours, recommendation to clarify the policy regarding medical treatment of a student without parental consent or a PCP referral and recommended enhanced guidance on Medicaid policies for SBHCs. FQHCs bill for Medicaid services using a federally established all-inclusive rate paid without regard to the nature of the medical visit.

In 2018, OMIG began a second audit of FQHCs billing EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screenings on the same date of service they bill for the encounter rate. Current Medicaid policy allows an FQHC to bill an encounter rate on the same date of service as an EPSDT screening if the documentation to support the billing of both services is present in the patient's chart.

Based on data analysis completed in early 2018, OMIG identified several FQHCs who were outliers for billing both the encounter rate and the EPSDT screening. Documentation was

requested from a selection of providers for further review. In this audit sample, it was determined that the medical records were lacking documentation to support the billing of both services.

Locum Tenens Billing

Section 292.780 of the Physician-Arkansas Medicaid Provider Manual establishes the proper use of a Locum Tenens provider as an arrangement made when the regular physician must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. Based on a complaint received by OMIG from the Department of Human Services, OMIG analyzed Medicaid claims for providers utilizing the Q6 modifier for Locum Tenens.
OMIG analyzed claims data for all Medicaid claims billed with the locum tenens modifier for dates of service June 1, 2015 through April 30, 2018. Based on this analysis, OMIG sent a PAL to four providers where data analysis identified 2,774 claims utilizing the Q6 modifier and requested that the provider disclose any improperly billed claims. OMIG is currently working with the providers to research and disclose these improper payments for this billing pattern.

Multiple Eye Exams

OMIG conducted data analysis that indicated that providers appeared to be billing for greater than one examination within a fiscal year. Section 243.150 of the Visual Care-Arkansas Medicaid Provider Manual provides that all beneficiaries 21 years of age and older are eligible to receive 12 office visits for medical services every state fiscal year. The utilization of this benefit limit is shared among four other programs: physicians' services, medical services provided by dentists, rural health clinic services, and certified nurse-midwife services. Extensions beyond the 12 visits may be provided if medically necessary. Additionally, Section 213.200 of the Visual Care-Arkansas Medicaid Provider Manual provides that all beneficiaries 21 years of age and older are eligible to receive one visual examination every twelve (12) months. Only one of the following codes may be billed for a visual examination during that twelve (12) month timespan: S0620, S0621, and 92014. Provider Awareness Letters (PAL) were sent to 142 providers based on the results of this data analysis asking the visual care providers to review their eye exam codes and report any improper billing. As a result of this PAL, OMIG received $1,706.15 in self-reports for improper claims paid for this billing pattern.

Initiatives

RSPMI CPT Procedure Codes 90885 and 90887

Through data analytics, OMIG identified multiple providers improperly billing for behavioral health procedure codes 90885 and 90887 on the same date of service for the same recipient. Under the Rehabilitative Services for Persons with Mental Illness (RSPMI) program, procedure code 90887 may not be billed for review of the master treatment plan with the parent, guardian or recipient. Review of the treatment plan is included as part of the service billed for through procedure code 90885.

In lieu of an OMIG audit, providers were asked to review summaries which identified improper billing for RSPMI procedure codes 90885 and 90887 on the same date of service for the same recipient for services provided to recipients from July 1, 2016-August 31, 2017. Additionally, OMIG asked providers to report/repay any inappropriately billed claims.

OMIG sent a total of 54 Provider Awareness Letters to providers and recovered a total of $11,360.92 in improperly billed claims. Additionally, the providers billing for RSPMI procedure codes 90885 and 90887 on the same date of service for the same recipient were asked to develop a Corrective Action Plan (CAP) to ensure that inappropriate billing does not occur in the future.

Initiatives

Recoupment Letters

OMIG expanded its provider awareness initiative of requesting providers to review specific questionable claims in Fiscal Year 2017. Rather than OMIG conducting full scale audit of these providers, the letters allowed OMIG to reach more providers in a less intrusive manner. OMIG analyzed claims data to identify providers who deviated significantly from their peer group. Letters were sent to outlying providers requesting review of the claims, self- report and return of any improper payments as well as submission of a corrective action plan.
Provider Recoupment Letters are submitted when OMIG is confident that an improper claim has been submitted and resulted in an overpayment. If there is no fraud suspected and no system edit in place to avoid these claims, OMIG notifies the provider of the issue and that the claims will be subject to recoupment.

The following provider recoupment letters were submitted in Fiscal Year 2018:

- Adult Allergy Immunotherapy over Age 21
- Services after Death
- Crossover Voids
- Duplicate Refraction
- NCCI Edits
- Home- and Community-based Services
- Inpatient Overlap
- Scope of the Program Claims
- Physician New Patient Office Visits
- Developmental Rehabilitation Services
- DDS Supportive Living

Adult Allergy Immunotherapy over Age 21

Through data analytics, OMIG identified instances in which Immunotherapy CPT Codes 95115-95199 were billed for beneficiaries aged 21 and older from January 1, 2015 through December 31, 2017. The Physician-Arkansas Medicaid Provider Manual establishes that allergy immunotherapy is payable only for eligible children under the Child Health Services Code. These services are not reimbursable for beneficiaries age 21 and older. OMIG sent a total of 67 recoupment letters and recovered a total of $26,340.56 in improperly billed claims.

Services After Death

On April 3, 2018, OMIG conducted a desk review of paid claims for 163 Medicaid providers. The review focused on the improper submission of claims for dates of service occurring after the recipient's recorded date of

death. The scope of this review was paid claims with dates of service between March 5, 2015 and October 12, 2017. Section 142.200 (A) of the Arkansas Medicaid Provider Manual states that any covered service performed by a provider must be billed only after the service has been provided. The Code of Federal Regulations Title 42, Part 433 (42 USC § 433.304) states that an overpayment is the amount that the Medicaid agency paid to a provider in excess of the amount allowable for furnished services. Medically necessary services cannot be furnished to a deceased recipient. Because of the letter initiative OMIG received documentation materials from 7 providers requesting reconsideration. Subsequent to those requests being granted, OMIG proceeded with a mass adjustment of the remaining 156 claims for a recoupment of $33,887.44.

Crossover Voids

Medicaid crossover payments occur when a beneficiary is eligible for both Medicare and Medicaid coverage. Pursuant to the Arkansas Medicaid Manual §332.300, if any Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit an adjustment and the Medicaid crossover payment should be recouped or reversed. For the third consecutive fiscal year, OMIG partnered with AdvanceMed, the Arkansas Zone Program Integrity Contractor to identify the crossover payments where the Medicare payment had been voided or reversed. Based on that data analysis, OMIG recovered $183,889.04 in Medicaid crossover claims in which the Medicare claim had been voided or reversed. In SFY 2019, OMIG will continue its review of paid Arkansas Medicaid claims affected by the void or reversal of an associated Medicare claim and continue to recover any improper payments identified.

Duplicate Refraction

Beginning in Fiscal Year 2017, OMIG identified multiple instances in which vision providers submitted duplicate refraction exam claims. OMIG investigations revealed that the duplicate claims resulted from incorrect interpretation of Medicaid regulations or problems with electronic billing software. Based on this analysis, OMIG sent recoupment letters and collected $162,517.00 in improperly billed refraction claims. Sections 242.110 and 243.120 of the Visual Care-Arkansas Medicaid Provider Manual states that HCPCS code S0620 and S0621 may be billed when a routine ophthalmological examination includes a refraction exam performed for a new or established patient. The CPT code 92015 may be billed for determination of refractive

state but must be performed alongside a medical exam. As HCPCS codes S0620/S0621 and CPT code 92015 both cover refraction exams, it is improper for a provider to bill both codes for the same beneficiary on the same date of service. OMIG data analytics conducted a review of claims data for the vision program which identified instances of this improper billing pattern. In Fiscal Year 2018, OMIG continued this initiative by repeating the data analysis to identify additional improper claims for duplicate refraction exams. The review revealed 27 providers where the duplicate claims resulted from incorrect interpretation of Medicaid regulations or problems with electronic billing software. OMIG sent recoupment letters to the 27 vision providers and recouped $13,248.40. Based on the results of the Fiscal Year 2018 study, there appears to be a significant decrease in improper billing for these procedures.

NCCI Edits

The Patient Protection and Affordable Care Act (H.R.3590) Section 6507 (Mandatory State use of National Correct Coding Initiative (NCCI)) requires state Medicaid programs to incorporate NCCI methodologies into their claims processing system. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported. Arkansas Medicaid implemented NCCI methodologies for claims with dates of service on or after April 1, 2011.

OMIG data analytics team identified $15,980.58 in overpayments from NCCI Procedure-to-Procedure (PTP) edits are CPT code pairs that, in general, should not be billed together. OMIG utilized PAL recoupment letters and sent 47 letters notifying providers of the overpayment and recoupment of these improper claims. OMIG will continue to test the NCCI edits and recoup improperly paid funds through our recoupment PALs.

HCBS and Inpatient Overlap

OMIG data analytics team identified 629 claims paid for Home and Community Based Services during the time Medicaid Beneficiaries were being treated in an Inpatient Facility from 07/01/2016 – 06/30/2017. The HCBS services are not necessary and must not be billed during an inpatient/hospital stay. OMIG sent 98 PAL recoupment letters and recovered $15,813.00. Most notably, OMIG made 9 referrals for fraud to the Attorney General's Medicaid Fraud Control Unit.

Initiatives

Scope of Program

ARChoices Scope of Program

Section 213.000 of the ARChoices-Arkansas Medicaid Provider Manual establishes the scope of services that are reimbursable under the Arkansas Medicaid Program. Services provided under that program include adult family home attendant care, home-delivered meals, personal emergency response, adult day, adult day health, respite, and environmental accessibility adaptations. Only procedures codes identified in the AR Choices-AR Medicaid Provider Fee Schedule are eligible for reimbursement.

In August 2017, OMIG conducted data analysis that focused on the improper submission of claims for services that are not reimbursable under the ARChoices program. The dates of service reviewed were July 1, 2016 through June 30, 2017.

As a result of this review, OMIG sent 7 letters to ARChoices providers and recovered $19,238.58 in improper payments to providers.

97530 Procedure Code Scope of Program

In February 2018, OMIG initiated a review of paid claims for CPT code 97530. The review focused on the submission of claims for services that are not reimbursable under the fee schedule for the provider type under which the claims were billed. The dates of service reviewed were January 1, 2015 through January 31, 2018. As a result of this review, OMIG sent 17 letters to Arkansas Medicaid providers who improperly billed CPT code 97530 and recovered $68,475.80 in improper payments for this initiative.

Physician New Patient Office Visits

Initial office visit CPT procedure codes must only be used for the visit of a new patient. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. Section 292.526 of the Physician-Arkansas Medicaid Provider Manual establishes the proper use of initial visit CPT procedure codes.

In August 2017, OMIG reviewed claims data for physician providers billing initial visit procedure codes. Claims were determined to be improperly billed if submitted in a frequency less than every 3 years for an initial office visit by the same billing and/or attending provider, or providers within the same specialty and subspecialty who belong to the same group practice.

Based on the findings of this review, OMIG sent 134 letters to providers billing for initial office visits and recovered $37,223.42 to date.

Initiatives

Developmental Rehabilitation Services

In February 2018, OMIG identified several Developmental Rehabilitation Services (DRS) providers who were billing for procedure code 97530 above the rate of reimbursement that is authorized for the DRS provider type. In the DRS program, procedure code 97530 is prior authorized by First Connections for $18.00. The providers identified through data were billing procedure code 97530 at a rate of $21.76, which was improper. OMIG sent a total of 29 recoupment letters and recovered $44,458.05 in improperly billed claims.

DDS Supportive Living

Recent OMIG reviews identified multiple instances in which DDS Supportive Living providers were paying direct care workers less than the DDS approved hourly rate listed on the Total Supportive Living Costs Worksheet (DDS ACS 110). The hourly rate paid to a direct care worker is determined by the provider and is used to set the total salary of the worker which is a factor in the calculation of the approved DDS

Supportive Living daily rate for a client. Hourly rates for direct care workers are approved by DDS and must be paid in the full amount. In lieu of an audit, OMIG sent Supportive Living providers a Provider Awareness Letter (PAL) requesting they review their payroll records for direct care workers for beneficiaries that received DDS Supportive Living services. The initiative resulted in 79 PALs sent to DDS providers and yielded a recoupment of $203,463.48.

Initiatives

Contract Review

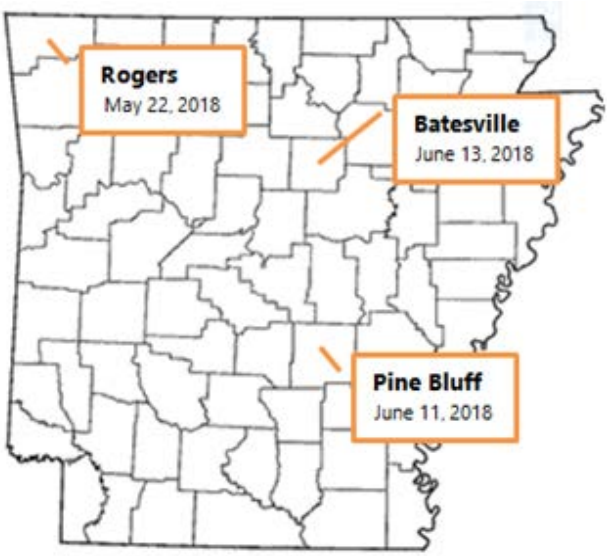
The Contract Administration Division was created within the Office of Medicaid Inspector General in September 2015. The purpose of the Medicaid contract reviews is to determine whether Performance-based Contracting standards are being followed, whether DHS is properly monitoring contract performance, and whether there are duplications with other contracts and/or programs. Consequently, both the contracts and the DHS Medicaid programs are analyzed. In 2018, the Contract Administration Division analyzed contracts and their related programs with the Arkansas Department of Health, Arkansas Foundation for Medical Care, Inc., Beacon Health Options, Inc., Emeritus Corporation dba Bock Associates, Inc., General Dynamics – Episode-based care delivery and payment model, and Navigant Consulting, Inc. Additionally, the Emergency Ambulance Program was analyzed, which involved review of rules and regulations from the Center for Medicare and Medicaid Services (CMS), the Department of Health, and DHS.

Provider Community Engagement & Staff Enrichment

Medicaid Recipient Fraud Detection Training

During the fourth quarter of Fiscal Year 2018, OMIG—in partnership with MFCU and the DHS Fraud Unit—launched a joint training session on Medicaid Recipient Fraud detection and awareness for DHS/DCO case workers, supervisors, and administrators.

Fiscal Year 2018 Fraud Detection Training Locations and Dates



Area 1 – Rogers; May 22, 2018
Area 2 – Batesville; June 13, 2018
Area 5 – Pine Bluff; June 11, 2018

The training targeted awareness of problem areas of fraud evident in the early stages when determining Medicaid recipient eligibility. The training sessions were initially presented to DHS/DCO administrators and eligibility specialist supervisors at pre-scheduled DHS/DCO quarterly area meetings with a recorded session made available for future training use with DHS/DCO case workers. Approximately 35 administrators and ES supervisors attended each training sessions at three DHS/DCO area locations throughout Arkansas.

Continuing Education

Throughout the year, OMIG staff has attended local and national conferences pertaining to program integrity, Medicaid policy, vendor contracts, and Arkansas Medicaid programs. OMIG staff members continue to attend training courses and other meetings at the Department of Justice, Center for Medicare and Medicaid Services, Medicaid Integrity Institute (MII), on the University of South Carolina campus in Columbia, S.C. These courses are provided to qualified state employees and are 100% funded by the federal government. In FY18, 11 OMIG personnel attended and completed 9 courses at the MII. OMIG personnel made several presentations at MII, including the biennial Data Experts Symposium,

which brings together research and data analytics professionals from state and federal agencies across the United States. Two OMIG employees successfully achieved the Certified Professional Coder (CPC) designation through courses at MII. As a result, there are now 5 OMIG employees with this important certification. Having CPC certification strengthens the credibility of our auditors and aides in communication among auditors, data analysts, and other medical professionals.

Conferences and Workshops

The Inspector General and other OMIG personnel have conducted presentations and provided training at multiple conferences and seminars throughout the year, including the Little Rock chapter of the American Academy of Coding Professionals, Arkansas Hospital Association, Community Health Centers of Arkansas, Arkansas Government Accountants, and other provider groups and state agencies. In addition to in-person conferences, OMIG personnel have also conducted online webinars, including an online presentation pertaining to OMIG's provider awareness letter (PAL) initiative. OMIG will continue to provide training and assistance to Medicaid providers, personnel and programs as part of the overall mission to educate and provide assistance to identify fraud, waste, and abuse in Medicaid. These provider contacts through presentations and attendance in training coupled with the provider awareness letters has resulted in an increase in provider self-reports and has enhance program integrity compliance by the providers

NAMPI

In August of 2018, Inspector General Smith and OMIG's Director of Audits and Investigations spoke at the National Association for Medicaid Program Integrity (NAMPI) conference in Austin, TX. OMIG presented an overview of the benefits and challenges associated with implementing the recommendations contained in "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services," the white paper released by CMS in November of 2017. Inspector General Smith also presented "Cost Avoidance Strategies to Drive Value from Data Analytics", with a Senior Program Integrity Manager from Optum. Although direct recoveries and traditional audits are a proven tool for promoting program integrity, OMIG educated attendees on how to conduct PALs and highlighted the value and success of OMIG PALs as a non-traditional technique to bring savings to State Medicaid agencies.