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DEPARTMENT OF PUBLIC WELFARE

Partnering in HealthChoices Behavioral Health Program Compliance



Partnership

Our purpose today is to provide training and to foster and develop ways to work in partnership to detect and prevent fraud, waste and abuse

Today we will discuss:

Definitions of fraud, waste and abuse and give examples

Provide information ~

- Self Auditing

- Screening of Employees

- Elements of a Compliance Program

- Statutes and Regulations on Program Integrity





Partnership

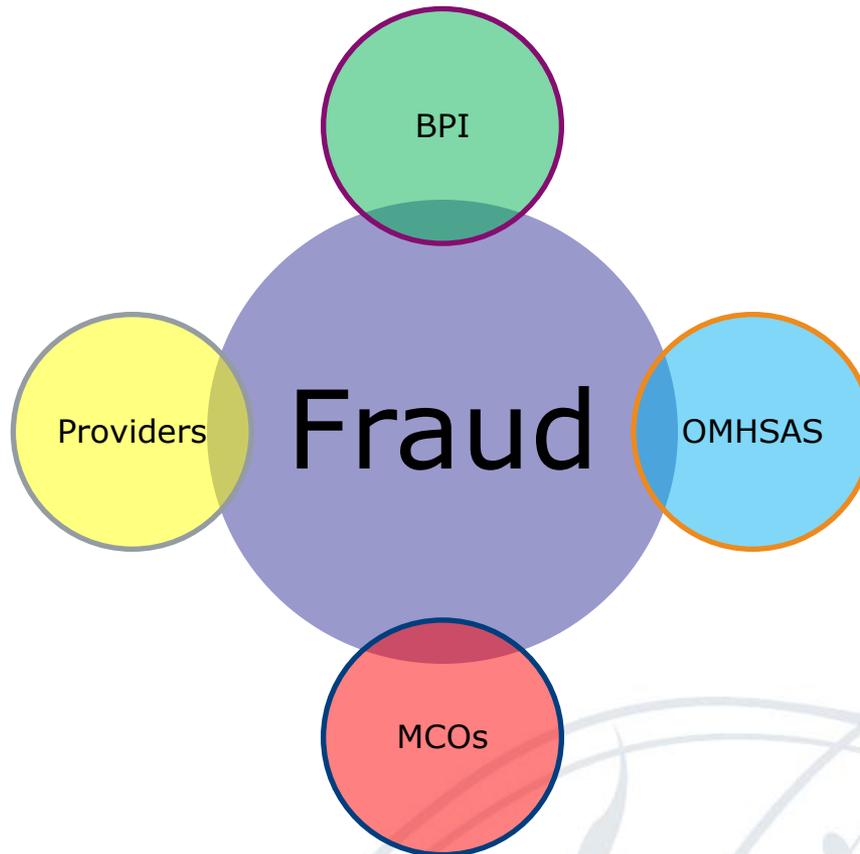
Together we can decrease future events of fraud, waste and abuse through:

- 1) Understanding laws, statutes and regulations**
- 2) Training staff on preventing and reporting suspected fraud, waste and abuse**
- 3) Incorporating the 8 elements of a compliance program**
- 4) Monthly screening of all potential and existing employees**
- 5) Periodic provider concurrent self – audits**



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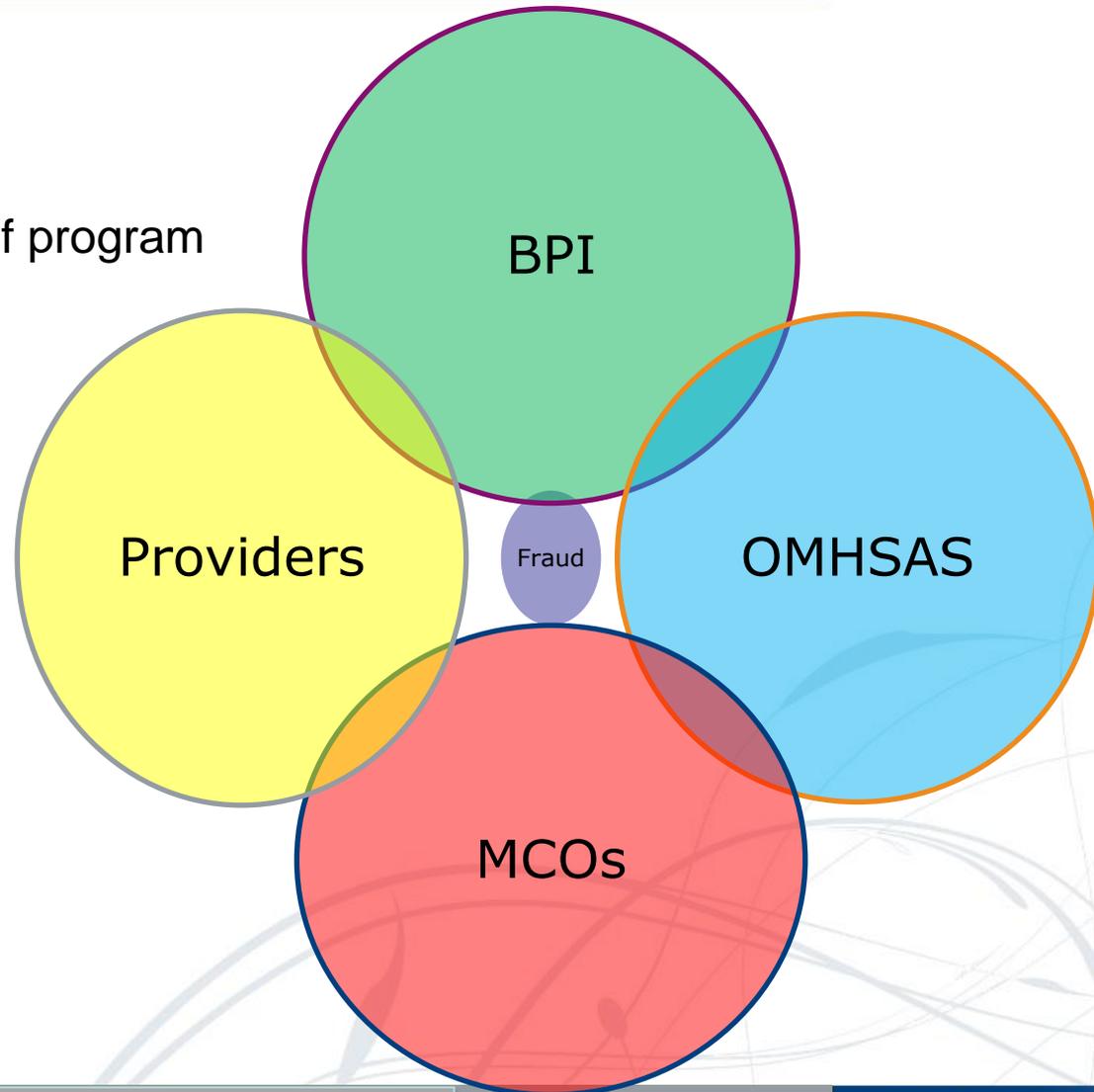
Using these tools and partnering with each other





Partnership

Helps us reduce the misuse of program dollars





Glossary of Acronyms

ACA	Affordable Care Act
BH-MCO	Behavioral Health Managed Care Organization
BPI	Bureau of Program Integrity
CHIP	Children's Health Insurance Program
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DHHS	Department of Health and Human Services
DRA	Deficit Reduction Act
EPLS	Excluded Parties List System
FFCA	Federal False Claims Act
FFS	Fee for Service
FWA	Fraud, Waste and Abuse
GAO	Government Accounting Office
IG	Inspector General



Glossary of Acronyms

LEIE	List of Excluded Individuals and Entities
MA	Medical Assistance
MCE	Managed Care Entity
MCO	Managed Care Organization
MIG	Medicaid Integrity Group
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
NHCAA	National HealthCare Anti-fraud Association
NPI	National Provider Identifier
OAG	Office of Attorney General
OIG	Office of Inspector General
PPACA	Patient Protection and Affordable Care Act
PERM	Payment Error Rate Measurement
PI	Program Integrity
SIU	Special Investigative Unit



Definitions

42 CFR Part 455

Program Integrity Requirements for Medicaid

455.2

Provides definition of fraud and abuse

Medicare Part D

Provides definition of waste



Definitions of Fraud, Waste and Abuse

What is Abuse in the Medicaid Program?

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Examples:

Services that are billed by mistake

Misusing codes~ code on claim does not comply with national or local coding guidelines; not billed as rendered

Billing for a non-covered service

Inappropriately allocating costs on a cost report



Definitions of Fraud, Waste and Abuse

What is Fraud in the Medicaid Program?

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Knowingly or intentionally submitting false claims.

Examples:

To purposely bill for services that were never given

To bill for a service that has a higher reimbursement than the service rendered

Rounding up of time



Definitions of Fraud, Waste and Abuse

What is Waste in the Medicaid Program?

Waste: As defined by CMS, Medicare Part D
“The overutilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather misuse of resources”.

Examples

Provider ordering excessive testing

Recipient using excessive services such as office visits

Usually very difficult to prove~ often a judgment call



Compliance

- Predicates
- Compliance Plan Requirements
- Policy and Procedures



Definitions of Fraud, Waste and Abuse

Predicates

- Medically Necessary Services
- Least Restrictive
- Appropriate Clinical Pathway



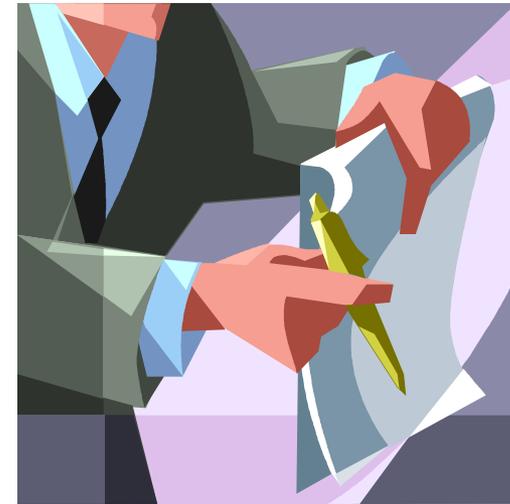
Compliance Plan Elements

- 1. Established written compliance standards, policies and procedures**
- 2. Specific high level individuals hold responsibility**
- 3. No delegation of substantial discretionary authority**
- 4. Effective internal and external communications**
- 5. Established monitoring and auditing systems designed to detect criminal activity**
- 6. Consistent enforcement through disciplinary mechanisms**
- 7. Response and corrective action must take all reasonable steps to respond to the offense**
- 8. Compliance Plan Overall Effectiveness**



Compliance Plan Elements

- 1. Established written compliance standards, policies and procedures**





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Compliance Plan Elements

2. Specific high level individuals hold responsibility





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Compliance Plan Elements

3 . No delegation of substantial discretionary authority





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Compliance Plan Elements

4. Effective internal and external communications





Compliance Plan Elements

5. Established monitoring and auditing systems designed to detect criminal activity





Compliance Plan Elements

6. Consistent enforcement through disciplinary mechanisms





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Compliance Plan Elements

- 7. Response and corrective action must take all reasonable steps to respond to the offense**



Compliance Plan Elements

8. Demonstrate Compliance Plans Effectiveness





Compliance Plan Elements

Policies and Procedures

Code of Conduct

Compliance Committee

Internal Audits

External Audits

Monthly Reports

Corrective Action Plans





Exclusions and Screening

No Federal health care program payment may be made for any items or services:

- Furnished by an excluded individual or entity or
- Directed or prescribed by an excluded provider

Payment prohibition extends to:

Payment for administrative and management services not directly related to patient care

Coverage of an excluded individual's salary, expense or fringe benefits

What does exclusion in federal health care programs mean?

Exclusion: To prevent the entrance of, to shut out or keep out

Who Should Be Screened?

- All employees, vendors, contractors, service providers, and referral sources



Exclusions and Screening

And the individual or entity~

- Functions that are a necessary component of providing items and services to Medicaid recipients
- Who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to DPW) regardless of whether they provide direct patient care

Proactive steps you can be taking now to minimize exposures with your labor force and contractors

MA Bulletin 99-11-05:

Suggests Medicaid providers do monthly screenings to look for excluded individuals and entities





Checking for Excluded Individuals

List of Excluded Individuals and Entities (“LEIE”)

Identifies individuals or entities excluded nationwide from participation in any federal health care program

If included on the LEIE ~Ineligible to participate, either directly or indirectly, in the MA Program <http://oig.hhs.gov/fraud/exclusions.asp>.

Excluded Parties List System (EPLS):

General Services Administration world wide data base

Parties excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and nonfinancial assistance and benefits

<https://www.epls.gov/>.



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Exclusions and Screening

DPW's Medichex List : Data base maintained by the Department

Providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program

http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichexprecludedproviderslist/S_001152

If you discover an excluded individual

Identify~

Immediately self report your findings to the Bureau of Program Integrity via e-mail through the MA provider compliance form at

<http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm>





Exclusions and Screening

Understand what actions are needed

Rectify~

Tell us your Corrective Action Plan (CAP)

Data analysis- root cause, what , when

Program analysis- identify operational procedure that cause error

Correct Action Plan- how will you correct error, moving forward

Implementation- when will you implement, timeframe

Evaluate/Monitor- how will you monitor moving forward



What are the risks for failure to do so?

Civil monetary penalty for employ of excluded individuals ~up to \$10,000.00

You could be excluded from participation in Federal health care programs including PA Medicaid

CYA: Keep a record of the dates you perform screening



Federal False Claims Act

- The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare (as well as Medicare Advantage (MA) and Medicaid programs. The Federal False Claims Act (FCA) applies to all federal funded programs.
- Under the FCA, any individual or organization that knowingly submits a claim he or she knows (or should know) is false and knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid or approved under any federally funded health care program is subject to civil penalties. It also includes those cases in which any individual or organization obtains money to which they may not be entitled, and then uses false records or statements to retain the money, and instances where a provider retains overpayments.
- Under the Federal False Claims Act, a person, provider, or entity is liable for up to triple damages and penalties between \$5,500 and \$11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program.
- In addition to civil penalties, individuals and entities can also be excluded from participating in any federal health care program for non-compliance.
- States also have False Claims laws that are similar to the federal FCA.



Examples of Violations of the False Claims Act

- A provider who submits a bill to Medicare or Medicaid for services that were not rendered.
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
- A provider that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.
- Submitting false information about services performed or charges for services performed;
- Inserting a diagnosis code not obtained from a physician or other authorized individual;
- Misrepresenting the services performed (for example, up-coding to increase reimbursement);
- Violation of another law. For example, a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (e.g.; a physician received kickbacks for referrals); and
- Submitting claims for services ordered by a provider that has been excluded from participating in Medicare, Medicaid and other federally funded healthcare programs.



Anti-Kickback Statute

- The Anti-Kickback Statute (42 U.S.C. § § 1320a-7b) is a federal law that prohibits persons from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs. These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value ("remuneration") in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program
 - For purposes of the Anti-Kickback Statute "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- Violations of the law are punishable by criminal sanctions including imprisonment and civil monetary penalties. The individual or entity may also be excluded from participation in Medicare or other federal health care programs for violating the Anti-Kickback Statute.
- An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the Office of the Inspector General (OIG). Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on the facts.
- Some states have enacted similar laws that apply to goods or services covered by the state health care programs and in some cases even private insurance.



Related to Fraud, Waste and Abuse Laws and Regulations

- Federal False Claims Act
 - Statute: 31 U.S.C. § § 3729-3733
- Anti-Kickback Statute
 - Statute: 42 U.S.C. § 1320a-7b(b)
 - Safe Harbor Regulations: 42 C.F.R. § 1001.952
- The Exclusion Authorities
 - Statutes: 42 U.S.C. § § 1320a-7, 1320c-5
 - Regulations: 42 C.F.R. pts 1001 (OIG) and 1002 (State agencies)
- Beneficiary Inducement law
- Whistleblower Protection Act
- Physician Self-Referral Prohibition (Stark Law)
 - Statute: 42 U.S.C. § 1395nn
 - Regulations: 42 C.F.R. § § 411.350-.389
- Civil Monetary Penalties Law (CMPL)
 - Statute: 42 U.S.C. § 1320a-7a
 - Regulations: 42 C.F.R. pt. 1003
- Criminal Health Care Fraud Statute
 - Statute: 18 U.S.C. § § 1347, 1349



Whistleblower Protection Act

- To encourage individuals to come forward and report misconduct involving false claims, the False Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a law suit on behalf of the U.S. government.
- The False Claims Act includes specific provisions to protect whistleblowers from retaliation by their employers. Any employee who initiates or assists with an FCA case is protected from discharge, demotion, suspension, threats, harassment and discrimination in the terms and conditions of his or her employment.
- Under federal law, the whistleblower may be awarded a portion of the funds recovered by the government, typically between 15 and 30 percent. The whistleblower also may be entitled to reasonable expenses, including attorney's fees and costs for bringing the lawsuit.
- In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from employer retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim, providing testimony, or assisting in a False Claims Act action
- A person who brings a qui tam action that a court later finds was frivolous may be liable for fines, attorney fees and other expenses.





Federal FWA Laws Statute

- **Self-Referral Prohibition Statute (Stark Law):**
 - Prohibits physicians from referring Medicaid & Medicare patients for certain designated health services (DHS) to an entity in which the physician or the physician's immediate family has a financial relationship unless an exception applies. Violations of the law are punishable by a civil penalty up to \$15,000 per improper claim, denial of payment, and refunds for certain past claims.
- **Civil Monetary Penalties Law:**
 - The Federal Civil Monetary Penalties law covers an array of fraudulent and abusive activities and is similar to the False Claims Act. Violations of the law may result in penalties between \$10,000 and \$50,000 and up to three times the amount unlawfully claimed.
- **Health Insurance Portability and Accountability Act [HIPAA]:**
 - Authorized the establishment of the Health Care Fraud and Abuse Control Program (HCFAC) under the U.S. Attorney General and the Office of the Inspector General (OIG). The goal is to coordinate federal, state and local efforts in combating FWA.



The Deficit Reduction Act of 2005

- The Deficit Reduction Act of 2005 (DRA), effective January 1, 2007, requires all entities that receive \$5 million or more in annual Medicaid payments to establish written policies that provide detailed information about the Federal False Claims Act, the administrative remedies for false claims and statements, applicable state laws that provide civil or criminal penalties for making false claims and statements, the whistleblower protections afforded under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.
- Established the Medicaid Integrity Program
 - <http://www.cms.gov/MedicaidIntegrityProgram/>
 - **Deficit Reduction Act FAQs:**
<http://www.cms.gov/smdl/smd/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1197237&intNumPerPage=10>



PA Regulation Resources

- Record Keeping Requirements
 - 1101 Regulations
 - MA Bulletin 19-97-10
 - MA Bulletin 29-02-02, 33-02-03, 41-02-02
- Pennsylvania Medical Assistance Provider Self-Audit Protocol
 - MA Bulletin # 99-02-13
 - Provides general background info on the Bureau of Program Integrity (BPI) and remind providers of the administrative sanctions available to BPI to ensure compliance with applicable regulations.
 - Provides info on the Provider Self-Audit Protocol
 - Applies to all providers enrolled in the Medical Assistance Program
- Part III. Medical Assistance Manual
 - <http://www.pacode.com/secure/data/055/partIIItoc.html>
- General Regulations
 - <http://www.pacode.com/secure/data/055/chapter1101/chap1101toc.html>
- Payment Regulations
 - <http://www.pacode.com/secure/data/055/chapter1150/chap1150toc.html>
- MA Bulletin
 - <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>
- Drug & Alcohol Facilities
 - <http://www.pacode.com/secure>



IDENTIFIED AUDIT EXCEPTION TRENDS

Over the past several years we have identified the following deficiencies when conducting Fraud and Abuse audits:

Missing Documentation

Notes not submitted with desk review information or notes missing at site reviews

Documentation supports fewer units than billed units

Billed for 3 hours of service in a partial program when member was only present for 2 hours

Billing for services not rendered

Provider billing for “no shows”



AUDIT EXCEPTION TRENDS

Billed the incorrect code/modifier resulting in a reimbursement difference

Billed for a extensive med check when documentation indicates that a routine med check was performed

Overlapping services

Billed a therapy session from 1-2 PM and billed a med check from 1:15-1:30

Rounding up of units

There was documentation present for a 5 minute phone call, however, the provider billed 15 minutes or 1 unit. Three five minute phone calls may not be bundled together to make one 15 minute unit





AUDIT EXCEPTION TRENDS

Billing for non-billable services

BHRS BSC billing for supervision of staff, completing paper work/administrative duties

No breaks in time from one venue or member to another

Services not performed by the billing provider

No treatment plans present in the records

Bundle billed when the member did not receive the required 4 days a week of service

Bundled methadone services must have documentation of 4 days a week of compensable service



AUDIT EXCEPTION TRENDS

Billing for travel when prohibited

Signature stamp used on progress notes

Treatment plans not signed by the member or reviewed by the provider

Identical or nearly identical evaluations or progress notes

Evaluations or progress notes containing only a few sentence changes, or a few words changed in progress notes

Greater than ten members participating in a group session

Documentation does not support the submitted claim



DOCUMENTATION REQUIREMENTS

Title 55 of the Pennsylvania code, Chapter 1101.51 (e), states that:

Providers shall keep records that “fully disclose the nature and extent of the services rendered to MA recipients, and that meet the criteria established in this section and additional requirements established in the provider regulations”.



DOCUMENTATION REQUIREMENTS

Chapter 1101.51 (e) states that:

“The record shall be legible throughout”

“Entries shall be signed and dated by the responsible licensed provider, alterations of the record shall be signed and dated.”

“The record shall indicate the progress at each visit, change in diagnosis, change in treatment, and response to treatment.”

“Progress notes must include the relationship of the services to the treatment plan.”



DOCUMENTATION SUMMARY

Each progress note should answer the following questions:

Where is the service being provided?

Why is the client there?

What specific intervention or service was provided to the member?

What was the member's response to the interventions?

What is the plan for follow-up?



DOCUMENTATION SUMMARY

An important note to remember:

PROGRESS NOTES THAT CONSIST OF MERE OBSERVATIONS DO NOT MEET REGULATORY REQUIREMENTS, THEREFORE, THOSE SESSIONS WOULD NOT BE CONSIDERED REIMBURSEABLE SESSIONS.



Ways to Monitor for Program Compliance

- Accessibility to the Requirements
- Documentation of the Requirements
- Measurements of Effectiveness
- Tools to monitor Compliance
- Process to Audit and Identify Compliance
- Mechanisms to Correct and Report Non-Compliance



Compliance Monitoring

1. Accessibility to the requirements

1. Know how to locate the following:

Regulations

Contract Requirements

Program standards

Best Practices

Routinely monitor for updates



Compliance Monitoring

2. Documentation of requirements

Maintained documentation of the following:

- Policies and procedures

- Process documentation

- Program integrity standards

- Compliance program and plan

Continuously review, update, and approve



Compliance Monitoring

3. Measurements of effectiveness

Set benchmarks and goals

Compliance program

Compliance plan

Evaluate compliance resources

Investigate when goals are not
achieved or obtainable

Determine risks to compliance program



Compliance Monitoring

4. Tools to monitor compliance and risks

Gap analysis

Process of determining a company's strengths and weaknesses in comparison to predetermined controls or standards

Risk assessments

Process of assessing a company's risk related to its compliance with contractual and regulatory requirements



5. Processes to audit compliance

- Audit plan

 - Internal financial audits and reviews

 - Claims audits

 - BPI self audit protocols



Compliance Monitoring

6. Mechanisms to correct and report noncompliance
 - Referral processes
 - Self disclosures
 - BPI
 - CMS
 - OIG
 - Contractor (BH-MCO)



Provider Self Audit Protocol

In it's commitment to promote an environment of openness and cooperation DPW encourages:

All provider types to voluntarily come forward and disclose any overpayments, improper payments or inappropriate payments of MA funds.

When a provider properly identifies an inappropriate payment and reports it to the MCO, and the acts underlying such conduct are not fraudulent, DPW will not seek double damages, but will accept repayment without penalty.



Provider Self Audit Protocol

Recommends that as part of an overall compliance program, providers conduct periodic self audits

Why Self Audit ?

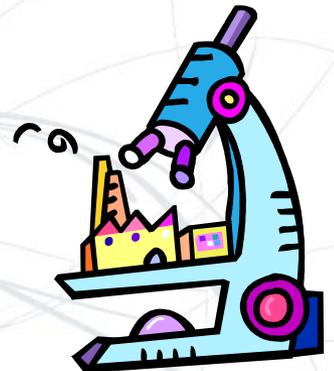
Since it is voluntary, the provider, not BPI, conducts the review

Reimbursement is accepted **without** penalty

Good tool to measure internal compliance

Ensures compliance with MA regulations

Provider can implement corrective measures





Provider Self Reporting

DPW recommends that providers conduct periodic audits to identify instances where services reimbursed by the MA Program are not in compliance with Program requirements.

DPW has had no formal mechanism or process for such self audits, but rather, has considered and evaluated each disclosure on an individual basis.





Provider Self Audit Protocol

Extrapolated Reviews using Statistically Valid Random Sampling (SVRS)

Sampling is a process of selecting a representative part of a population of claims data in order to estimate accuracy without collecting and individually reviewing data for the entire population

- Utilizing a Statistically Valid Random Sample (SVRS), BPI can measure the accuracy of a provider's medical claim data without reviewing all the medical records for a given time period
- By selecting this sample randomly from a total universe of claims for a provider, the sample then validly represents the entire population of claims for the given criteria and time period of the review



Provider Self Reporting

- Extrapolation from a SVRS is the scientifically valid estimation of an overpayment amount where by any realized error rate calculated from the sample is applied across the entire universe of claims
- This methodology is available for all providers to review and use as part of the provider approved self audit protocol document available on the DPW website:
<http://www.dpw.state.pa.us/Business/FraudAbuse/003670226.htm>.





Self Audit Advantages

- The use of statistical sampling has been fully accepted by the Federal courts as a method of estimating liability for overpayments.
- The Pennsylvania Medical Assistance Program is authorized both by law and regulation to use statistical sampling. (See 62 P.S. § 1407 (c) (1) and 55 Pa.. Code § 1101.83(a))
- DPW's, Bureau of Program Integrity (BPI) has been effectively using extrapolation audits since February 2001.





Provider Self Reporting

State Regulations - 55 PA Code

- Chapter 1101- General Provisions
 - apply to **all** enrolled providers
 - based on state and federal laws
- Chapter 1150 - Payment Policies
- Other: Bulletins, Provider Handbook/Billing Instructions

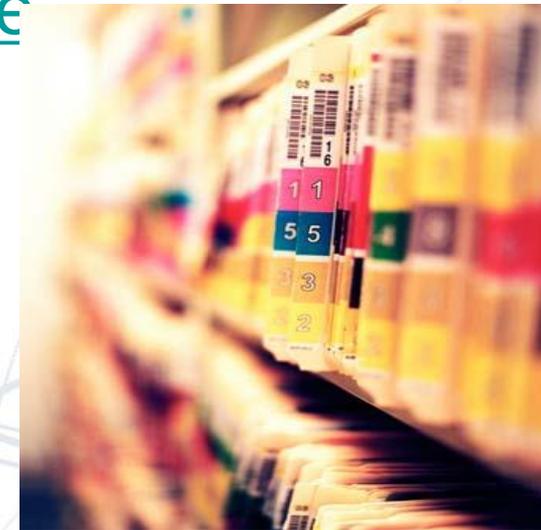




Provider Self Reporting

Available at the following link:

- http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceproviderselfauditprotocol/S_001151





Provider Self Audits

Remember

- Providers self report ~ self disclose

No penalty/ interest for self-identified overpayments



Provider Self Reporting

U.S. Department of Health & Human Services Office of Inspector General



[OIG Home](#) > [About OIG](#) > [Office of Audit Services \(OAS\)](#) >

OAS RAT-STATS Software

Adobe® Acrobat® is required to read PDF files.

RAT-STATS is a package of statistical software tools designed to assist the user in selecting random samples and evaluating the audit results. The goal behind RAT-STATS was to develop valuable analytical tools that could be easily used by auditors.

▶ [Download RAT-STATS for Windows \(Zip\)](#)

Extract zip files to a folder on your hard drive. Run SetupRS2007v2.exe and follow the installation instructions.

About RAT-STATS

RAT-STATS is the primary statistical audit tool used by the Office of Audit Services. Developed by the Regional Advanced Techniques Staff (RATS) in San Francisco, it has been used by the Office of Inspector General since the early 1970s. With the arrival of microcomputers, there was opportunity to move the statistical software from the mainframe timeshare systems.

In September 1987, the first microcomputer version of RAT-STATS was developed to run on IBM compatible computers using Microsoft's Disk Operating System (MS-DOS).

In September 2001, Windows RAT-STATS Version 1, which includes the most frequently used programs from the DOS version, was completed. Windows RAT-STATS 2007 includes all programs from the DOS version.

Related Information

[User Guide \(PDF\)](#)

[Companion Manual \(PDF\)](#)

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Regulation Examples...

Record Keeping

Record Keeping Requirements – 55 PA Code § 1101.51(e) and MA Bulletin 19-97-10

Signature

No Physician's Signature – 55 PA Code § 1101.66(b)(2)

Misrepresentation

Misrepresentation of the Identity of the Prescriber – 55 PA Code § 1101.75 (a)(8) and MA Bulletin 19-02-08

Misrepresentation of the Recipient – 55 PA Code § 1101.75(a)(8)

Misrepresentation of the Description of Service – 55 PA Code § 1101.75(a)(8)

Misrepresentation of the Date of Service – 55 PA Code § 1101.75(a)(8)



Part III. Medical Assistance Manual : <http://www.pacode.com/secure/data/055/partIIItoc.html>

General Regulations: <http://www.pacode.com/secure/data/055/chapter1101/chap1101toc.html>

Payment Regulations: <http://www.pacode.com/secure/data/055/chapter1150/chap1150toc.html>



Compliance Resources

• **FREQUENTLY USED LINKS FOR REVIEW ACTIVITIES**

- Code of Federal Regulations (CFR): <http://law.justia.com/cfr/>
- Title XIX SS Act: http://www.socialsecurity.gov/OP_Home/ssact/title19/1900.htm
- Pa. Code Title 55: <http://www.pacode.com/secure/data/055/055toc.html>
- Pa. MA Regulations (55 Pa. Code):

<http://www.dpw.state.pa.us/publications/forproviders/regulationshandbooksguidesandmanuals/medicalassistanceregulations/index.htm>

- Pa. MA Bulletin Search: <http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx>
- Pa. PROMISe Billing Guides
- <http://www.dpw.state.pa.us/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm>
- Pa. MA Provider Self Audit Protocol:
- http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicalassistanceprovidersselfauditprotocol/S_001151



Compliance Resources

- Pa. Medichex List:
http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichexprecludedproviderslist/S_001152
- **Precluded/Excluded Provider Checks**
- Excluded Parties List System (EPLS): <https://www.epls.gov/>
- OIG List of Excluded Providers (LEIE): <http://oig.hhs.gov/fraud/exclusions.asp>
- Search: <http://exclusions.oig.hhs.gov/>
- **DPW MA F/A Websites**
- <http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/mafraudandabuse/healthcarecompliancewebsites/index.htm>
- PA Office of Attorney General: <http://www.attorneygeneral.gov/index.aspx>
- US DOJ OIG: <http://www.justice.gov/oig/>
- DHHS OIG: <http://oig.hhs.gov/index.asp>



Compliance Resources

- DHHS OIG Work Plan:
<http://oig.hhs.gov/publications/workplan/2011/>
- OIG Corporate Integrity Agreements:
<http://www.oig.hhs.gov/fraud/cias.asp>
- DEA Diversion Control Program-Database:
http://www.deadiversion.usdoj.gov/crim_admin_actions/
- CMS Home Page: <http://www.cms.gov/>



Statutes and Regulations for Program Integrity

OIG Resources

- **OIG homepage:** <http://oig.hhs.gov/>

- **OIG Fraud Prevention & Detection webpage:** <http://oig.hhs.gov/fraud.asp>
Provides links to various OIG industry guidance documents (e.g., compliance program guidance, advisory opinions, fraud alerts, special advisory bulletins) as well as links to information on enforcement actions and reporting fraud.

- **OIG's Compliance Program Guidance:**
<http://oig.hhs.gov/fraud/complianceguidance.asp>
Includes compliance program guidance materials for various industry sectors.

- **Corporate Responsibility and Corporate Compliance Guide:**
<http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf>

- **OIG Advisory Opinions:** <http://oig.hhs.gov/fraud/advisoryopinions.asp>
 - o Frequently Asked Questions about the Advisory Opinion Process:
<http://oig.hhs.gov/fraud/advisoryopinions/aofaq.asp>



Statutes and Regulations for Program Integrity

OIG Resources

□ **OIG's Self-Disclosure Protocol:** <http://oig.hhs.gov/fraud/selfdisclosure.asp>

□ **OIG Exclusions:** <http://oig.hhs.gov/fraud/exclusions.asp>

□ **Anti-Kickback Safe Harbor Regulations:**

<http://oig.hhs.gov/fraud/safeharborregulations.asp>

Provides the regulatory history of the safe harbors. The current text of all the regulatory safe harbors is available at: http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr1001.952.pdf.

□ **Medical Identity Theft & Medicare Fraud:** <http://oig.hhs.gov/fraud/IDTheft/>

□ **OIG Fraud Hotline:** <http://oig.hhs.gov/fraud/hotline/> or 1-800-HHS-TIPS

□ **OIG Brochure "A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse":** <http://oig.hhs.gov/fraud/PhysicianEducation>

□ **Subscription to OIG's E-mail List** with Notifications of New Online Materials:
<http://oig.hhs.gov/maillinglist.asp>



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CMS and Other Resources

- **CMS homepage:** <http://www.cms.gov/>
- **CMS Contacts Information Page:** <http://www.cms.gov/ContactCMS/>
Lists public contact lines for CMS offices and provides a portal for accessing information about CMS national and local operations and key CMS programs.
- **CMS Contacts Database:** <http://www.cms.gov/apps/contacts/>
Provides access to searchable directories of contacts on national and local levels for the Department of Health and Human Services, CMS offices, Fiscal Intermediaries, and Carriers.
- **CMS Regional Office Overview:** <http://www.cms.gov/RegionalOffices/>
Provides downloadable files containing CMS Regional Office contact information.
- **CMS Physician Self-Referral Law (“Stark Law”) Information:**
<http://www.cms.gov/PhysicianSelfReferral/>
Provides overview and links to relevant law, regulatory materials, and guidance documents, including a Frequently Asked Questions page.



Statutes and Regulations for Program Integrity

CMS and Other Resources

□ **CMS Physician Self-Referral Law Advisory Opinions Library:**

http://www.cms.gov/PhysicianSelfReferral/95_advisory_opinions.asp

Includes information on requesting CMS Advisory Opinions and links to the CMS Physician Self-Referral Disclosure Protocol, as well as links to a disclosure process overview and relevant background information.

□ **HIPAA Privacy and Security Rules:**

<http://www.hhs.gov/ocr/privacy/index.html>

<http://www.cms.gov/HIPAAGenInfo/>

□ **National Plan and Provider Enumeration System:**

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Contains information regarding registering for a National Provider Identifier.

□ **Homepage for U.S. Departments of Health & Human Services and Justice Joint Campaign against Health Care Fraud:** <http://www.stopmedicarefraud.gov/>

□ **Website managed by the U.S. Department of Health & Human Services regarding Affordable Care Act:** <http://www.healthcare.gov/>





Partnership

Feedback Discussion

Next Steps

Wrap Up





Contact Information

Tammy Miller, LCSW
QI Director
Magellan Behavioral Health of PA,
Phone: 610-814-8042
TLMiller@Magellanhealth.com

Sara Collins, MSS, LCSW
Compliance & Claims Auditor
Magellan Behavioral Health of PA
Phone: 610-814-8013
SLCollins@magellanhealth.com

DJ Dunlap, Ph.D.
CBHNP SIU Manager
8040 Carlson Rd.
Harrisburg, PA 170112
Office: 717-671-6554
Cell: 717-514-5254
Fax: 717-671-6571
CBHNP an AmeriHealth Mercy Company

Melissa S. Hooks, Ph.D.(c), M.S., C.F.E.
Director of Compliance
Value Behavioral Health of Pennsylvania
Melissa.hooks@valueoptions.com
(724) 744-6513 (34-6513)
(724) 744-6303 (fax)

Cynthia Callen Zaber RN
Director of Fraud and Abuse
Community Care Behavioral Health
callencl@ccbh.com
610-594-2835

Pamela Hunter, Supervisor
Department of Public Welfare
Bureau of Program Integrity, MCO Section
116 East Azalea Drive
Harrisburg, PA 17110-3594
Phone: 717-772-5309 Fax: 717.772.4638
www.dpw.state.pa.us

Julie E. Barley, Acting Director Eastern Operations
DGS Annex/Beechmont Building #32
21 Beech Drive
Harrisburg, PA 17105
Phone: 717-772-6728
Fax: 717-705-8165

