Provider Enrollment/Program Integrity

- First step in preventing fraud, waste, and abuse

- Ensures quality people are providing services to vulnerable populations

- Ensures the right type and number of providers are available to serve the Medicaid population

- Improves the integrity of the program

Provider Enrollment Program Integrity Activities

- Provider enrollment
- Contract suspensions and terminations
- Affordable Care Act (ACA) Initiatives and Enhanced Screenings:
  - Ownership and disclosure
  - Ordering, prescribing, or referring (OPR)
  - Federal database checks and reporting
  - Assigned risk levels – Elevated risk level
  - On-site visits
  - Revalidation
  - Fingerprint criminal background check (FCBC)
  - Termination and denial of enrollment

Ownership and Disclosure

- Person or corporation having a 5 percent direct or indirect ownership or controlling interest in a disclosing entity.

- Officers or directors of a disclosing entity formed as a corporation or partner (if formed as a partnership)

- Need to disclose identifying information: SSN or Tax ID, DOB, Name and address, relationships, the same information for managing employees

- Criminal convictions

Ordering, Prescribing and Referring (OPR)

- OPR's must be enrolled in Medicaid

- If submitting claims – fully enrolled

- If ordering, prescribing or referring only – OPR enrolled

- The OPR's NPI is required on the servicing provider's claims

- Consequences: If the OPR only provider doesn't enroll then the billing provider's claims won't be paid

Federal Database Checks and Reporting

- Social Security Death Master File (SSDMF)
- National Plan & Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE) through the Office of Inspector General (OIG)
- System Awards Management (SAM) aka Excluded Parties List System (EPLS)
- Any other state database to verify license information

Assigned Risk Levels

- <u>Limited Categorical Risk</u>

o Requires provider to meet federal and state requirements for the provider type

o License verification

o Conduct data base checks to ensure the provider meets enrollment criteria for their provider type

- <u>Moderate Categorical Risk</u>

o Perform "limited" screening requirements

o Conduct on-site visit

- <u>High Categorical Risk</u>

o Conduct "limited" and "moderate" screening requirements

o Conduct fingerprint based criminal background check

Elevated Risk

- Under certain circumstances the provider's screening category must be elevated to the "high" risk category.

- Payment suspension based on credible allegation of fraud, waste or abuse. Risk level remains "high" for 10 years beyond the date of payment suspension

- The provider has been excluded by the Office of Inspector General or another state's Medicaid program

- The agency or CMS in the previous 6 months lifted a temporary moratorium for a provider type

- Provider has an existing overpayment of $1500* or greater
  - Is more than 30 days old
  - Has not been repaid
  - Is not currently being appealed
  - I not part of an approved repayment plan for the entire overpayment
    - *The $1500 threshold is an aggregate of all outstanding debts and interest

On-site Visits

- Conducted for "moderate" and "high" categorical risk providers

- Conducted at initial enrollment, re-enrollment and revalidation

- Unannounced

- Must terminate or deny enrollment if the provider fails to permit access to a location

Provider Revalidation

- Mandated to verify information on file for all existing Medicaid providers

- All enrolled providers must revalidate or will be terminated for non-compliance

- DMEPOS suppliers must be revalidated every 3 years

- All other providers must be revalidated every 5 years

- Fiscal agent notifies providers of their revalidation timeframes

Fingerprint Criminal Background Check

- On July 1, 2017, the DHCFP implemented the fingerprinting requirement.

- High risk providers are required to be fingerprinted at initial enrollment, re-enrollment and revalidation of enrollment.

- Providers are notified during the time of enrollment whether they are required to complete a FCBC.

Termination and Denial of Enrollment

- States must terminate or deny provider enrollment if:
  - Non cooperation with screenings
  - Failed to submit requested information
  - Convicted of criminal offenses related to a federal or state health care program in the last 10 years.
  - Terminated or denied enrollment in another state
  - Failed to submit to a fingerprint background check

- States can terminate or deny enrollment if:
  - Doesn't meet the conditions of participation in the Nevada Medicaid program
  - Falsified information on the enrollment application and documents
  - The state cannot verify the providers identity

Managed Care Final Rule

- Became effective May 6, 2016
- All Managed Care network providers must be enrolled in Fee for Service Medicaid
  - Ensures all applicable ACA screenings are completed prior to enrolling in an MCO network
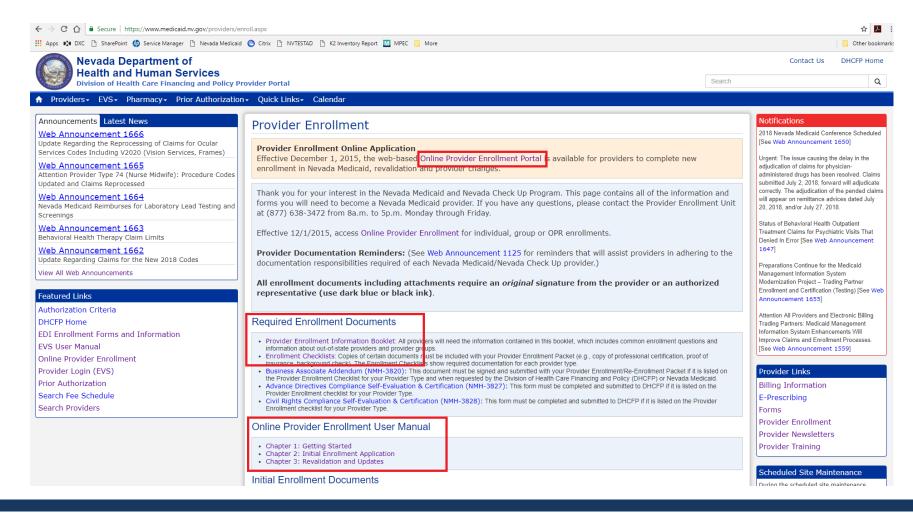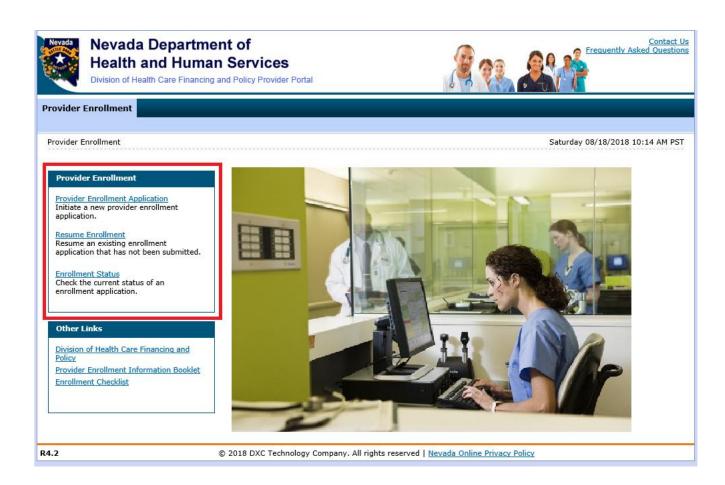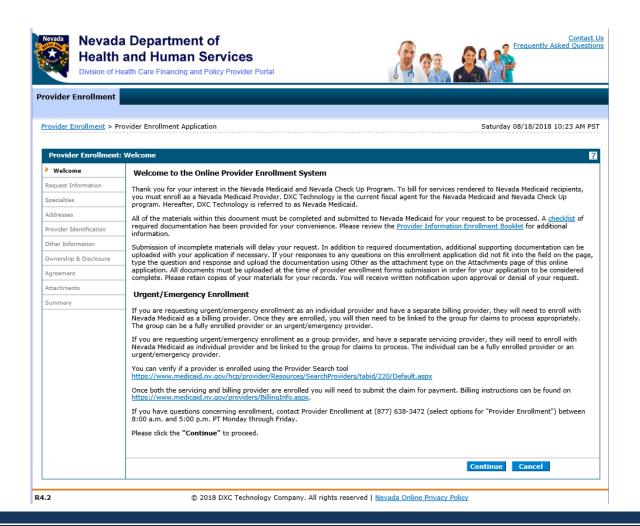 - Network providers are not required to see FFS recipients
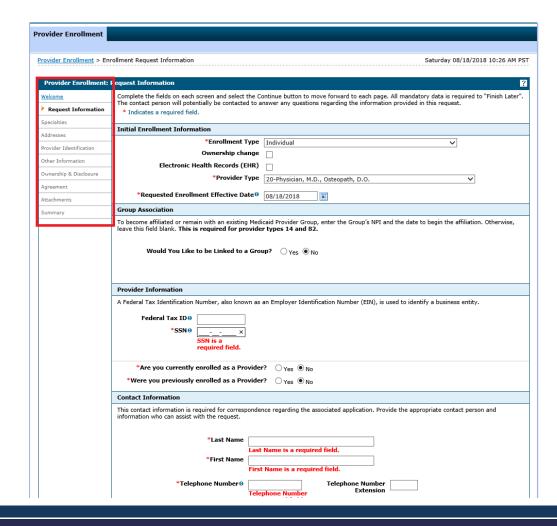
QUESTIONS?

Online Provider Enrollment

Provider Enrollment Page

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Electronic Verification System (EVS)

Electronic Verification System (EVS)

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Electronic Verification System (EVS)

Online Provider Enrollment

QUESTIONS?

Brian Sandoval
Governor

Marta Jensen
Administrator
Division of Health Care Financing and Policy

DHCFP – PROGRAM INTEGRITY

Surveillance and Utilization Review (SUR) Unit

WE IDENTIFY, RECOVER AND PREVENT FRAUD, WASTE, ABUSE, AND IMPROPER PAYMENTS IN NEVADA MEDICAID SYSTEM.

- We refer all credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU).

- **WASTE** - unnecessary or inefficient services, possibly including the following

  ➢ Prescribing a wheelchair to a recipient who is ambulatory
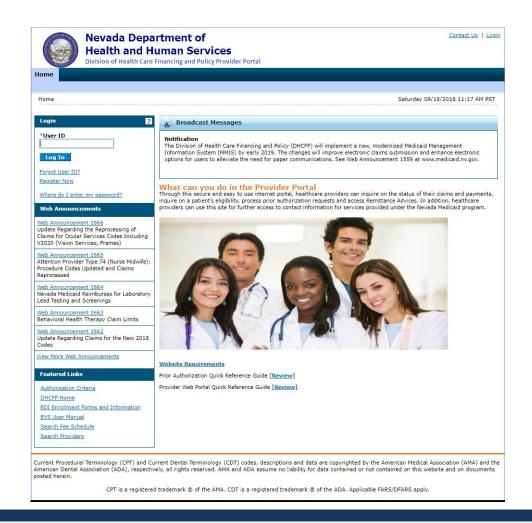
  ➢ Scheduling ongoing therapy sessions when progress is unattainable

  ➢ Duplicating diagnostic testing unsupported by physician orders

- **ABUSE -** failure to bill according to policy guidelines, possibly including instances of

   ➢ Submitting claims that do not accurately reflect the services provided

   ➢ Submitting claims that do not adhere to policy, professional standards, or coding guidelines found in ICD-10, CPT, HCPCS Level II

IMPROPER PAYMENTS

In addition to looking for fraud, waste and abuse, we look for improper payments. Improper payments include overpayments due to errors in provider billing or payer claim processing.

EXAMPLES OF CASE REFERRAL SOURCES

➢ Complaints / Referrals (including provider self-referrals)

➢ Onsite Visits

➢ Verification of Service Letters

  ✓ Fiscal Agent sends 500 per month to recipients, similar to EOB

  ✓ SUR sends on an ad hoc basis to recipients and service providers

➢ Data Mining and Analysis of Paid Claims

➢ Information Shared by other States and CMS

EXAMPLES OF CORRESPONDING ACTIONS

➢ Educate on policy violations

➢ Request a provider conduct self-audit

➢ Recoup overpayments of paid claims

➢ Request suspension of payments

➢ Request termination of provider contract/exclusion

With so many insurance payers, it is easy for good providers to overlook or misunderstand billing details. This could lead to unintentional errors.

What can you do to minimize improper billing and overpayments?

Some things to focus on ….

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

➢ Know Medicaid Services Manual Policy

dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

✓ <u>All providers</u>

Chapter 100	Medicaid Program
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Addendum	Definitions

✓ <u>Specific Provider Types</u>

All other Chapters 200 - 3900

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

➢ Access the Provider Portal – often! Resources include items below:

www.medicaid.nv.gov/home.aspx

✓ <u>Billing Information</u>   Broken down by Provider Type

✓ <u>Web Announcements</u>   Breaking news and important information

✓ <u>Application and Forms</u>   Prior authorization, provider contract, appeals, provider information changes and much more

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

➤ Understand and comply with:

✓ <u>Medical Coding Rules</u>   Including ICD-10, CPT, HCPCS Level II

✓ <u>Service Documentation Requirements</u>   Guidelines can vary by service, provider type

✓ <u>Prior Authorization Limits</u>   Guidelines will vary by service, provider type

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

➢ Bring your billing questions to:

    ✓ Nevada Medicaid Fiscal Agent   877-638-3472, Option 2

➢ If further clarification is needed:

    ✓ DHCFP Provider Type Policy Specialist   775-684-3676, Option 0

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

➢ Report provider fraud, waste, abuse, and improper payments

    ✓ **NPI** (Nevada Program Integrity)   775-687-8405

    ✓ **Online Form**

    dhcfp.nv.gov/Resources/PI/ContactSURSUnit/

SURVEILLANCE AND UTILIZATION REVIEW (SUR) UNIT

QUESTIONS?