Useful Tools for a Compliant Medicaid Provider

A presentation for Dental providers

October 28, 2021

Presented in Partnership by:

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

Before We Begin…

THANK YOU
for participating in the
NJ FamilyCare program!

Disclaimer

This presentation is intended for general educational purposes only.

It does not replace your responsibility to seek professional guidance, observe all laws and regulations that pertain to your practice as a Medicaid provider and exercise sound, independent, professional judgment.

Medicaid (NJ FamilyCare)

- Throughout this presentation the words Medicaid and NJ FamilyCare may be used interchangeably.

- NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion, with services provided through the State and the five Medicaid Managed Care Organizations (MCOs).

Goals for Today

To help you better understand:

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

Questions?

If you have questions throughout the course of the presentation please put them in the chat.

What is Medicaid?

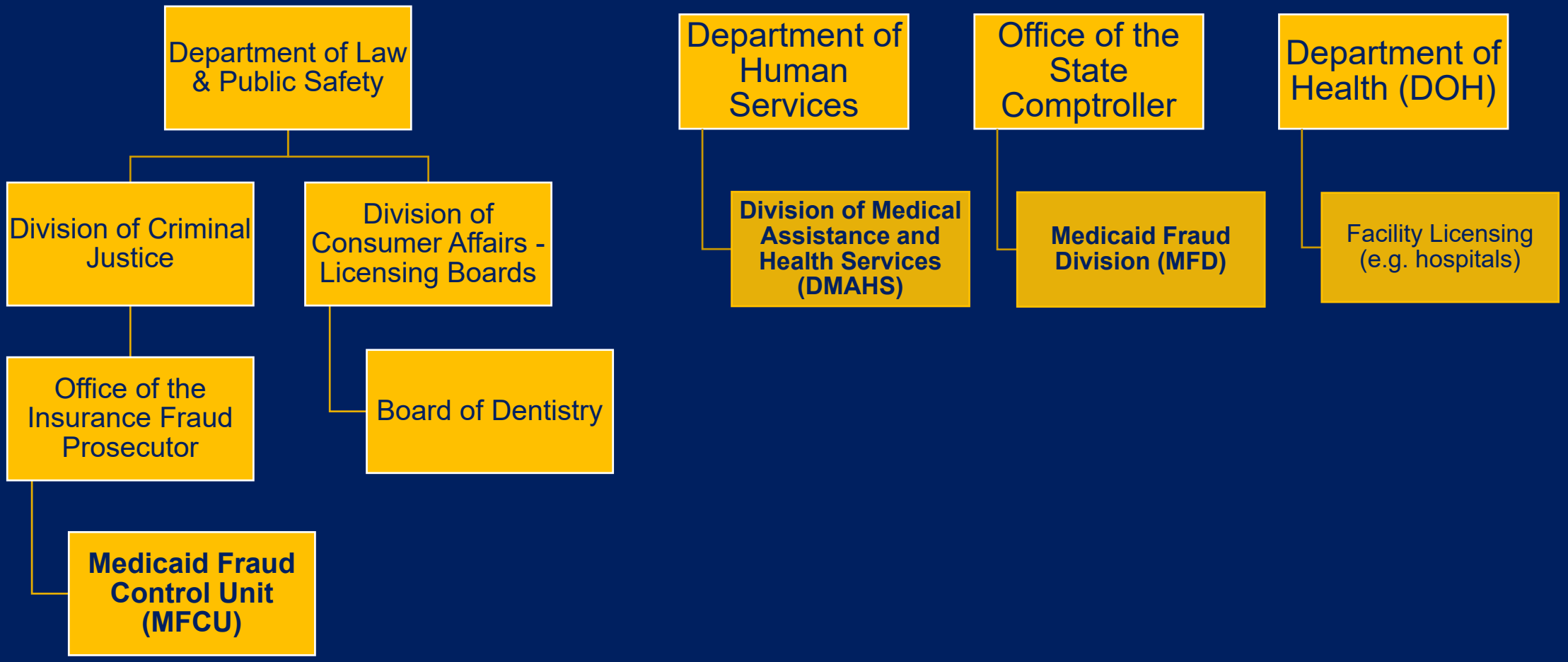
- Medicaid is a joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals.

- Medicaid participation is voluntary. If you want to participate, you must know, accept and abide by the rules and regulations. Your continued participation requires compliance with the regulatory requirements.

Medicaid Dental Services

In New Jersey, dental services for Medicaid (NJ FamilyCare) recipients are provided both through Managed Care and Fee For Service.

New Jersey Agency Administration and Medicaid Oversight



Medicaid Managed Care Contract

DMAHS has a contract with the following MCOs:

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

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

- Effective January 1, 2018 the 21st Century Cures Act 114 P.L. 255, requires all Medicaid Managed Care network providers to enroll with the State Medicaid program or risk being removed from the Managed Care Network.
- Enrollment in the State Medicaid Program as part of 21st Century Cures Act does not require the Provider to accept NJ Medicaid Fee for Service (FFS) beneficiaries.
- Enrollment as a 21st Century Cures Act Provider does not allow a Provider to bill Fee for Service Medicaid.
- Newsletter Volume 30 No. 18

Fee For Service Provider Enrollment

To enroll in NJ Medicaid/NJ FamilyCare Program:

- Call: 609-588-6036 and request that an application be mailed to you, OR;
- Visit Gainwell Technologies at www.njmmis.com
  - Find “Communication” on left banner bar
  - Click “Provider Enrollment Application”
  - Download the appropriate application package
- All fields on the application must be completed, even if information is not applicable (if not applicable enter N/A).
- All necessary supporting documentation (licensing board certification, etc) must be attached.
- Anything not completed will cause the application process to stop and the package will be returned to the provider.
- For dentists, revalidation occurs every 5 years from the providers effective date

MCO Credentialing and Re-credentialing

Common issues that can delay credentialing and re-credentialing:

- Incomplete Application
- Missing signatures
- Non-responsive to outreach

MCO Credentialing and Re-credentialing

Helpful Tips (To avoid application delays)

- Make sure that all of the provider's credentials are up to date
- Review all documentation for required signatures
- Reply to all outreach to enable timely processing of the provider application
- Some (not all) MCOs require the provider to be enrolled with the Council for Affordable Quality Healthcare, Inc. (CAQH) as part of the credentialing process. If the plan(s) you are credentialing with require this, ensure you are enrolled with CAQH and your information is up to date.

MCO Credentialing and Re-credentialing

Frequency

- All providers must undergo re-credentialing at a minimum of every three years, from the date of their last credentialed date. Failure to comply with the re-credentialing requirements could result in the termination of the provider's participating status and be reported to the National Practitioner Data Bank (NPDB). If terminated, the provider must cease treating NJ FamilyCare members until the re-credentialing requirement has been met.

MCO Credentialing and Re-credentialing

Completion

- Initial MCO Credentialing is not complete until the provider has received notification of their acceptance by the MCO.
  - Upon acceptance, the provider will be notified of the credentialing committee's decision and, if approved, be added to the MCOs Network.
  - Until credentialing is complete, providers are not allowed to treat NJ FamilyCare members. If provider treats Medicaid recipients prior to the completion of credentialing, no reimbursement is allowed.
  - An authorization is required for services rendered by nonparticipating providers.

MCO Credentialing and Re-credentialing

NPI Requirement

- Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider, and Service Facility Location, if applicable.
- The NPI is required by the State of New Jersey's Division of Medical Assistance and Health Services for both electronic and paper claims submissions.
- All practitioners of facilities serving members are required to comply with this requirement.
- Providers are prohibited from billing under the NPI number of a different provider.

About the Medicaid Fraud Division (MFD)

The New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. 30:4D-53 et seq. established the Office of the Medicaid Inspector General to detect, prevent, and investigate Medicaid fraud and abuse, recover improperly expended Medicaid funds, enforce Medicaid rules and regulations, audit cost reports and claims, and review quality of care given to Medicaid recipients. These functions, powers and duties were later transferred to the Office of the State Comptroller (OSC), and are carried out by the Medicaid Fraud Division (MFD).

About the Medicaid Fraud Division

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

About the Medicaid Fraud Division

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

The Medicaid Fraud Division partners with licensed NJ dentists to review and evaluate quality of care concerns.

Guiding Regulations – Dental Services

NJAC 10:56

- Regulation N.J.A.C. 10:56
- Currently under revision
- Please refer to NJMMIS Newsletters, which update N.J.A.C. 10:56 regulations

Guiding Regulation – Dental Services

- New Jersey State Board of Dentistry (NJSBoD): Chapter 30:13

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

Public Health Emergency (PHE)

- Teledentistry is currently allowed in response to the PHE.
- Current Newsletter: Volume 28 No. 17
- Should it be maintained as a program benefit, a subsequent Newsletter would advise.

Six Steps Towards Compliance

1. Providing the Clinically Appropriate Service
2. Adhering to Waiver and Regulatory Standards, where applicable, including hiring practices, properly completing Medicaid application, and training yourself and all staff about their requirements
3. Accurately Documenting the Services
4. Instituting Responsible Billing Practices
5. Properly Supervising all Employees' Provision of Services
6. Establishing a System to Identify and Correct Errors and Omissions concerning Credentialing, Documentation and Billing

Accurately Documenting Services

Documentation requirements for Medicaid Dental Providers

Documentation requirements arise from a variety of sources

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

Accurately Documenting Services

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

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

Records Retention Timelines

Record retention timelines vary depending upon the source:

- N.J.A.C. 13:30 – 8.7 (Board of Dentistry): 7 years
- Article 7.28.A of the MCO contract: 10 years

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

Medicaid Documentation Requirements

- Providers shall agree to the following:
  - To keep such records necessary to fully disclose the extent of services provided, and to retain individual records for the greatest length of time that applies from the date the service was rendered;
  - To timely furnish information about such services as requested by regulatory agencies, including the Medicaid Fraud Division;
  - If records do not document the type and extent of services billed, payment adjustments are necessary, including requiring repayment to Medicaid or claim payment denial.

Documentation Requirements – Forms and Formats

- There are generally two types of medical records, either handwritten or Electronic Health Records (EHR).
- Regardless of the type of record, the content must be accurate and complete. It must fully record the diagnosis, services provided and include notes about what occurred and when appropriate, expected outcomes.
- Records must document all services billed, including time if required for the billing code.
- If a prior consult with a physician is required before performing dental procedures, document who and when consulted, and include all pertinent medical history.

Documentation Requirements – Forms and Formats

- Accurate notes of services are important both for continuity of care by other providers and to properly support that the services billed were rendered.

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

Documentation

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

- Individual's name
- Date of service
- Signature of person authoring the note
- Signature of supervisor if required

Record must reflect all elements for which provider bills

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

If Using Handwritten Records

- Content and signature in notes must be legible

Documentation

Notes MUST:

- Align with the service or treatment plan's outcomes and strategies
- Answer the who, what, when, where and why of service provision
- Be completed by either the individual providing the service OR an individual responsible for the oversight of the direct service provision. If the note is completed by a staff member not providing the direct service, they should have documentation to support the information contained in the note.
- Reflect progress toward or decline from identified outcomes
- Comply with dental board requirements as detailed by N.J.A.C. 13:30 – 8.7

Documentation

Notes MUST:

- Providers using an electronic health record (EHR) or other electronic system must ensure that all information required in mandatory sections is included and individualized for the recipient and that all underlying documentation can be produced to support services rendered during an audit.
- Use of the behavior management code must describe the clinical presentation as well as the medical condition. Behavior management is used for the additional treatment time. You must demonstrate medical necessity in the record.

Documentation

Notes CANNOT:

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

Documentation

Records/documentation must accurately reflect the services that were rendered.

Documentation should occur at the same time as services rendered.

Don’t shortchange yourself...

If it’s not documented or not documented correctly, it wasn’t done.

Medicaid will not pay for undocumented or improperly documented services.

Chart Requirements

- Medical history reviewed /documented at each visit
- Legible entries
- Clinician sign/initial entries
- Any radiographs taken and associated diagnosis
- Treatment plan (clinical findings and diagnosis) discussed and accepted by patient
- Informed consents present for general or surgical treatment, where necessary
- Accurate description of treatment documented
- Documentation of any adverse events
- Post-op instructions and care documented
- Scheduled next appointment or recalls
- Periodontal status documented (to include occlusion) for adult or appropriate younger patients
- All services billed were performed as documented

Documentation – Hospital/Surgery Center Operating Room

- Resources to Consult:
  - Newsletter: Volume 25 No. 14
  - Provider Manual for each MCO
- Documentation of Medical Necessity to support treating patient in operating room vs. office.
- Letter of Medical Necessity and documentation of dental disease/conditions are necessary for prior authorization for anticipated dental procedures.
- Informed consent for treatment signed by patient or legal guardian.
- Operative notes listing diagnosis, clinical findings and procedures completed.

Regulatory Standards

- Provider is responsible to verify with documentation that:
  - Staff is qualified and trained - verify credentials, certification, licenses, establish training schedule
  - Background check performed ensuring that new or potential staff have no disqualifying criminal issues before permitting provision of services
  - Exclusion checks must be performed monthly

Institute Responsible Billing Practices

Billing and Coding

- The use of specific codes by the provider that accurately report the services rendered are required to receive payment for those services
- The codes that are used on the claim form are:
  - CDT code for a specific service, or
  - Unspecified codes(s) based on category of service.

Responsible Billing Practices

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

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

Identify and Correct Errors

- Implement a robust system of quality assurance and oversight that reviews compliance on an ongoing basis and adjusts service delivery to maintain outlined standards.
- Supplemental documentation to a note can be added if necessary, as long as the date of the addition is included as well as the initials of the person supplementing the record.

Consequences

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

Fraud

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

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

Civil Medicaid Fraud, Waste and Abuse Consequences

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

Waste

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

Abuse

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

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

- unnecessary costs to or improper payment by Medicaid

OR

- reimbursement for services that are not necessary, not approved, not documented, that are outside those specifically authorized.

Waste and Abuse

Professional Due Diligence

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

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

Examples of Dental FWA

- Billing for Services Not Rendered
- Unbundling
- Up Coding
- Altering Dates of Service
- Billing for Treatment Not Completed
- Performing Unnecessary Services
- Misuse of NPI Numbers

Example of Inappropriate Findings:

- Billing for crowns at impression date and not insertion date.
- Auto-billing for orthodontics. Claims should only be submitted on date of service.
- Claim date of service not matching chart entry.
- Non-credentialed providers treating members.
- Billing for exam (D0140) at every visit when procedure calls for multiple visits (i.e. making of dentures, crowns, etc.).
- Billing for behavior management without reflecting the need for such management and the additional time required.

Dental FWA Case Examples

- Patient had a routine simple extraction but provider billed for a surgical extraction
- Parent advised by Pediatric Dentist that child had 14 cavities. During second opinion was advised child had zero cavities
- Non credentialed provider billing under the NPI number of credentialed provider
- Patient had a regular cleaning but office billed for a scaling and root planing
- Patient had a sealant but dentist billed for a filling
- Billing travel codes for multiple patients residing in a single facility

Case Example: Misuse of NPI numbers

Civil Monetary Penalties and Affirmative Exclusions

The Office of Inspector General (OIG) has the authority to seek civil monetary penalties (CMPs), assessments, and exclusion against an individual or entity based on a wide variety of prohibited conduct. In each CMP case resolved through a settlement agreement, the settling party has contested the OIG's allegations and denied any liability. No CMP judgment or finding of liability has been made against the settling party.

OIG Enforcement Cases

The cases listed below represent recently-closed cases initiated by the OIG's Office of Counsel to the Inspector General. To view additional cases, including those resolved through the provider self-disclosure protocol, click on the specific categories to the right.

Related Information

- Background

CMP Navigation

- Civil Monetary Penalties and Affirmative Exclusions
- Provider Self-Disclosure Settlements
- Civil Monetary Penalty Authorities
- Reportable Event Settlements

07-02-2018

New Jersey Pediatrician Settles Case Involving False Claims

- On July 2, 2018, Rashmi Sandeep, MD (Dr. Sandeep), Brick, New Jersey, entered into a $336,298.52 settlement agreement with OIG. The settlement agreement resolves allegations that Dr. Sandeep knowingly presented to Medicaid, through certain New Jersey Medicaid Managed Care Organizations (MCOs), claims for items or services that she knew or should have known were not provided as claimed and were false or fraudulent. Specifically, OIG alleged that Dr. Sandeep: (1) submitted or caused to be submitted claims for items or services provided to Medicaid beneficiaries, who were enrolled with certain MCOs, in which Dr. Sandeep failed to personally perform or directly supervise services billed under her NPI number because she was either not present in the United States or was otherwise not in the State of New Jersey; (2) caused the resubmission of previously denied claims for items or services provided to Medicaid beneficiaries enrolled with a particular MCO by identifying herself as the rendering provider when, in fact, she was not; and (3) submitted or caused to be submitted claims for items or services provided to Medicaid beneficiaries enrolled with a particular MCO under her NPI number for services performed by non-credentialed providers who were not supervised by Dr. Sandeep. Associate Counsel Srishti Sheffner represented OIG with the assistance of Paralegal Specialist Mariel Filtz.

Criminal Health Care Claims Fraud

N.J.S.A. 2C:21-4.3

- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims.
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license

False Claims

Did you know…

- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.

Excluded, Suspended or Disqualified Providers

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

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

- It is incumbent upon providers to perform Exclusion Checks, upon hire and monthly thereafter

Medicaid Exclusion List Requirements

MFD Exclusion List Requirements:

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

MFD Recovery Actions

Once an overpayment has been identified as a result of an investigation or audit, MFD initiates actions for recoupment of improperly paid funds:

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

Self-Disclosure

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://nj.gov/comptroller/resources/#collapseSub30/

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

- Providers who follow the protocols for a proper self-disclosure can avoid imposition of penalties.

- MFD's Self Disclosure Form: https://nj.gov/comptroller/news/docs/self_disclosure_form.pdf

Third Party Liability

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

- Third Party Liability exists when any entity or party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program. Examples of Third Party Liability (TPL) are Medicare, commercial health insurance and Tricare.

- By law Medicaid is the payer of last resort. All TPL, shall, if available, be used first and to the fullest extent to pay claims before Medicaid/NJ FamilyCare pays for the care of the Medicaid recipient.

- It is a violation of Section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services (NJAC 10:49-7.3).

Medicaid Fraud Control Unit (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud Prosecutor (OIFP) is the criminal oversight entity.
- MFCU investigates and prosecutes Medicaid Fraud.
- The MFCU utilizes attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

Medicaid Fraud Control Unit

The MFCU investigates and prosecutes alleged criminal actions:

- Allegations of physical abuse to beneficiaries
- Healthcare Providers who are suspected of defrauding the Medicaid Program
- Fraudulent activities by providers against the Medicaid program.
- Fraud in the administration of the program.
- Fraud against other federally or state funded health care programs where there is a Medicaid nexus.

Medicaid Fraud

Bottom line:

Ignorance of the law excuses no one.

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

Questions? Please contact us!

Division of Medical Assistance and Health Services:

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

Medicaid Fraud Division

Email: provider-education@osc.nj.gov

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

Medicaid Fraud Control Unit

Email: NJMFCU@njdcj.org

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

Fraud Hotlines

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

Third Party Liability

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

Questions?

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

provider-education@osc.nj.gov

How did we do?

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


Thank you!