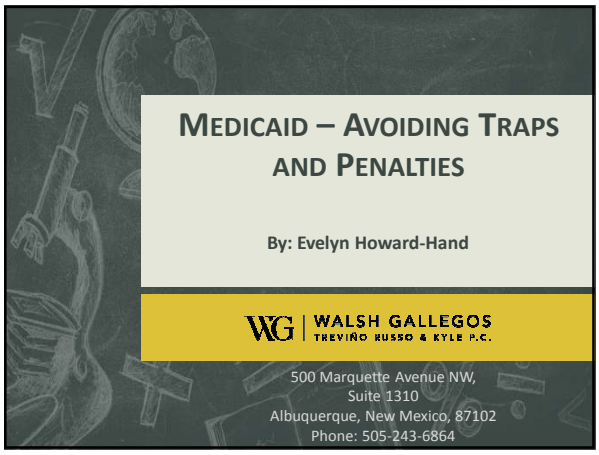

MEDICAID – AVOIDING TRAPS AND PENALTIES

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"Healthy children and youth have a better chance of achieving academic, social, and personal success than children and youth who are singled out by a health concern or disability that impacts their ability to participate in school. Because of their position in the daily lives of children, youth, and their families, New Mexico schools are poised to offer unique advantages and opportunities that can help families access health information, medical and behavioral health services, and facts about Medicaid enrollment. Through the MSBS program, New Mexico schools also offer key health and health-related services that are designed to integrate and maintain active learning for Medicaid-eligible children and youth with special education and health care needs." *New Mexico Medicaid Guide for School-Based Services 2017*

WHAT IS MSBS?

MSBS stands for Medicaid School-Based Services.

- ❑Medicaid-covered benefit
- ❑Authorized by the Medicare Catastrophic Coverage Act of 1988
- ❑Your District must have a Government Services Agreement with the Human Services Department Medical Assistance Division (HSD/MAD) and a Provider Participation Agreement with HSD/MAD through its fiscal agent (Conduent) to participate
- ❑Reimbursement for Eligible services
- ❑Reimbursement for Medicaid-related administrative activities
- ❑Provides Health and health-related services to benefit all students

MSBS Goals

- ❑Enroll students in the Medicaid Program.
- ❑Increase access to comprehensive health services for children and youth through the MSBS program.
- ❑Increase and maximize the financial resources available for school-based services.
- ❑Increase collaboration between schools, families, community providers, and state agencies, so that each partner has a defined role and demonstrates commitment and accountability to the MSBS program.
- ❑Develop and implement standards for providing or linking comprehensive health services through the schools.
- ❑Develop and implement a long-range plan to ensure the sustainability of a comprehensive MSBS program.

Who is an Eligible Student?

What criteria must a child meet in order for the district to bill Medicaid under the MSBS program?

- ❑The child must:
  - ❑ be enrolled in public school's special education program;
  - ❑ be between the ages of 3 and 20 years of age;
  - ❑ have an IEP documenting the medical necessity for services
  - ❑ have a disability or chronic medical condition; and
  - ❑ Medicaid eligibility.
- ❑The parent must consent to the District's use of Medicaid.

The services the child receives at school do not affect the type or amount of Medicaid services the child received outside the school.

What are Eligible Services?

- ❑Audiology services
- ❑Occupational, physical and speech therapy
- ❑Mental health services
- ❑Nursing services
- ❑Transportation
- ❑Nutritional Assessments and Counseling
- ❑Case Management

PROVIDER REQUIREMENTS

- Medicaid participation provider agreement and number
  - (except OTA, PTA, SLP apprentice)
- Board certification and licensure
  - Occupational therapists
  - Physical therapists
  - Speech-language pathologists
  - Licensed master's level clinical/independent social workers (LCSWs/LISWs), licensed master's level social workers (LMSWs) and Licensed bachelor's level social workers (LBSWs)
  - Licensed registered nurses and licensed practical nurses

PROVIDER REQUIREMENTS (CONT.)

- Board License
  - Audiologists
  - Speech-language pathology clinical fellows
  - Licensed marriage & family therapists (LMFTs)
  - Licensed professional clinical counselors (LPCCs)
  - Licensed mental health counselors (LMHCs)
  - Licensed psychiatric clinical nurse specialists
  - Licensed nutritionists, and registered dieticians
- PED license – School psychologists

STUDENT THERAPISTS AND INTERNS

- Provided in accordance with state and national standards of their professional Association
- Associated with an approved educational program
- Under the supervision of a licensed and Medicaid-enrolled supervising therapist.

What are eligible administrative activities?

- Medicaid-related outreach
- Facilitating Medicaid eligibility determinations
- Coordinating transportation to Medicaid-covered services
- Making referrals
- Coordinating and monitoring Medicaid services
  - Centennial Care managed care organizations (MCOs)
- Engaging in medical service program planning
- Policy development
- Interagency coordination

Direct Service reimbursements

- Quarterly Interim reimbursement direct services at the NM Medicaid Fee for Service CPT Code Fee Schedule
- Annual cost settlement
- State share generally around 30%
- Federal match of approximately 70%

Administrative reimbursements

- Calculated on time study model
- Reimbursement at a rate of 50% of federal funds
- Must certify the remaining 50% comes from state general funds

Random Moment Time Studies

- Used as basis for annual cost settlement and quarterly administrative claims
- Allows MSBS to determine the proportion of direct medical services and administrative activies
- Randomly selected cross section of providers during a specified moment on a certain date
- Validity checks – RMTS must be 85% complete

Documentation Requirements

- A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. 42 CFR 431.107(b).
- Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

Documentation (cont.)

- Records must be maintained for six years.
- At a minimum, records must include:
  - The name of the LEA, REC, or SFEA;
  - The recipient's name, date of birth, and Medicaid number/unique identifier;
  - The date and location of the service;
  - The procedure code for the service;
  - A description of the service provided, including the diagnosis code and level of service;
  - Signatures and credentials of the rendering provider(s). When the rendering provider works under the supervision of another provider, the supervisor must also sign the document.; and
  - The document showing involvement of the student's PCP or documentation of the LEA's, REC's, or SFEA's good faith attempt to obtain a response from the PCP in accordance with Section IV, Part VI of this Guide.
- Must support the medical necessity of the services (Present Levels of Academic and Functional Performance and Evaluations)

Documentation of Administrative Activities

- The accounting information upon which the claim form is based, including the basis for any inclusion or exclusion of costs;
- A list of all revenues that were offset when calculating the claim;
- The enrollment lists used to determine the Medicaid eligibility rate;
- Time study documentation, including the sample pool participants by function, title, name, identification number, location, telephone number, and code assigned to their activity;
- The completed quarterly claim;
- A copy of the warrant;
- Job descriptions of employees included in the sample pool;
- Proof of employee attendance for individuals included in the sample pool; and
- Any other supporting information used to substantiate the claim.

Failure to Maintain Records

- Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment.
- Failure to maintain records for the required time period is:
  - A violation of the Medicaid Provider Act. NMSA 1978 section 27-11-1, et. seq.
  - Punishable under the Medicaid Fraud Act, NMSA, section 30.44-5.

Monitoring

- The Medicaid School Health Office conducts a review of MSBS sites once within a 4-year cycle
- Random audit includes review of:
  - IEPs
    - Present Levels of Performance
    - Goals
    - Schedule of Services
    - Supplemental Aids and Services
  - PCP authorization
  - Service delivery logs
  - Attendance records
  - Billing records
  - Provider credentials

TRAPS

- Billing Errors and over-billing
  - Billing for services not delivered
  - Billing at incorrect rate (under or over)
  - Computer error
  - Billing on holidays, weekends, or dates of student or therapist absence
- Lack of documentation
  - No Notice to Parent of Medicaid rights
  - No consent for Medicaid billing
  - No physician's authorization/prescription
  - Lack of documentation of medical necessity
  - No provider number
  - Lack of provider credentials
  - Failure to document supervision of student/intern
  - Accurate documentation of student attendance

TRAPS (CONT.)

- Improper or inadequate documentation
  - Weak present levels of performance
  - Conflicting service times
  - Services on school holidays or weekends
  - Billing for more than the time specified in the IEP
  - Billing for less time than that specified in the IEP
  - Insufficient provider notes
    - Description of activity, measurable outcome, plan for future session

APPLICABLE LAWS AND PENALTIES

- Affordable Care Act
- False Claims Act
- False Statements Act
- Civil Monetary Penalties Law
- New Mexico False Claims Act

Affordable Care Act

- Overpayments must be returned within 60 days of date identified
- Identified – "when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment"
- Overpayments not repaid within 60 days become a liability under the False Claims Act

Overpayments

- Funds that a person or entity receives or retains in excess of the Medicaid allowable amount;
- For purposes of NM regulation, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as a third-party liability.

8.308.22.9 (C) NMAC

When is a payment identified (state law)

- Deemed identified when the provider:
  - Learns of incorrect coding or quantities of services
  - Learns recipient died prior to service date;
  - Learns services were provided by an unlicensed or excluded individual;
  - Internal audit reveals overpayment
  - Informed by Governmental agency of audit
  - Experiences significant increase in Medicaid revenue for no apparent reason
  - Hotline call or email to MCO
  - Notified by MCO that allegation made that individual didn't receive services or goods

8.308.22.9 (C)(1) NMAC

Reporting Overpayments

- Applies to overpayments identified within six years of receipt of reimbursement
- Must report by the later of:
  - 60 days after identified; or
  - The date any corresponding cost report is due, if applicable [81 FR 7653; 8.308.22.9 (C)(2) NMAC]

Reporting overpayments (cont.)

- Self-reports (overpayment reports) must include:
  - Provider name;
  - Provider tax ID number and national provider number;
  - How overpayment was discovered;
  - Reason for overpayment;
  - Date of service;
  - Medicaid claim control number, as appropriate
  - Description of corrective action plan
  - Specific dates within which problem existed
  - Whether a statistical sample was used to determine overpayment
  - Refund amount

8.308.22.9 (C)(3) NMAC

False Claims Act

- Provides for Qui Tam action
  - Suit by private party on behalf of the federal government
  - Filed under seal for 60 days (or longer) and not served on Defendant until ordered by Court
  - Relator can recover up to 30% of the proceeds of the case and potentially attorneys' fees, costs, and expenses [31 U.S.C. 3730(d)]
- Liability for knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval. That could include claims for services not rendered.

False Claims Act (cont.)

- Knowledge includes deliberate ignorance and reckless disregard of truth or falsity. This may include lack of documentation that the service was medically necessary.
- Penalties
  - Not less than $5,500 and
  - Not more than $11,000;
  - PLUS
  - Treble damages
  - Amounts are adjusted for inflation

Civil monetary penalties law

- Prohibits:
  - Failing to timely report
  - Billing for Medically Unnecessary Services
  - Submitting a false or fraudulent claim
- Applies when person knew or should have known
- Penalties –
  - not more than $50,000 per claim for false billing
  - Recoupment of three times the amount claimed
  - Exclusion from future participation
  - Knowing and willful misrepresentation – Anti-Kickback Statute

Civil Monetary Penalties Law (cont.)

- Factors considered in assessing penalties:
  - the nature of the claims and the circumstances under which they were presented;
  - the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and
  - such other matters as justice may require.

NM Medicaid False Claims Act

- Investigations and referrals to HSD
- Release to MFEAD
- Allows Qui tam suits
- Civil monetary penalties
  - $500 per false or fraudulent claim plus amount up to maximum allowable under federal or state law
  - Interest on amount received
  - Legal fees and costs of investigation and enforcement

Practical guidance

- Utilize the NM Medicaid Guide for School-based Services Quality Assurance Checklist
- Use a software program specifically designed for Medicaid billing
  - Quality control
  - Real-time data on claim status
  - Follow-up on rejected claims
  - Validation of claims on all key areas of compliance:
    - Parent consent
    - Random moment time study
    - School holidays
    - Duplicate entries
    - IEP specificity
    - Medicaid eligibility
    - Age
    - Prescription on file for services such as OT and PT
    - Provider licensure or certification
    - Federally funded providers

Practical guidance (cont.)

- Software (cont.)
  - Reports
    - Summaries or detailed views of claims submitted and billed amounts
    - Summaries or detailed views of claims accepted, denied, or rejected and payment amounts
    - Summaries of claims paid by check date or date of service over multiple timeframes
    - Financials by student, procedure, campus or service provider
    - Certification of Funds (COF) Letter data for services paid during a quarter
    - Service provider sessions' status and data input
    - District rates
    - Student Information
    - Cost report IEP ratio, transportation student count, and transportation trip count

PRACTICAL GUIDANCE (CONT.)

- Require providers to:
  - Sign in and out at campuses
  - Enter notes at time of services
  - Document make-up sessions
  - Attend training annually
  - Document if service is provided on a field trip or community-based instruction
- Require supervisor review of time entries for transportation and educational aides

PRACTICAL GUIDANCE (CONT.)

- Maintain sign-in/sign-out sheets for providers and staff at each campus for six years
- Conduct random audits of all required documentation and:
  - Provider service delivery logs
  - Whether services were in compliance with IEP
  - Student absences and services billed
  - Weekend and holiday billing
  - Billing rates

PRACTICAL GUIDANCE (CONT.)

- Third-party billing company
  - Proven Experience
  - Knowledge of legal requirements
  - Internal quality system
  - Insurance
  - Indemnity provision
  - Electronic billing software
  - Secure file transfer method
  - Software with ability to exchange data with District's student management software
  - Provides training

PRACTICAL GUIDANCE (CONT.)

- ❑Treat Government Inquiries like a legal claim for overpayment
  - ❑Consult an Attorney
  - ❑Conduct an internal review/audit
  - ❑Complete self-report if errors are found

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