GUIDANCE AND BEST PRACTICES RELATING TO THE

STATES' SURVEILLANCE AND UTILIZATION REVIEW FUNCTIONS

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<u>EXECUTIVE SUMMARY</u>

This document is the result of the efforts of a State/Health Care Financing Administration (HCFA) workgroup formed to address concerns expressed by the States' staffs as a result of statutory changes found in the Balanced Budget Act (BBA) of 1997. Section 4753, Modification of Medicaid Management Information System (MMIS) Requirements**,** of the BBA eliminated the Systems Performance Review (SPR) for MMIS. When Congress eliminated the SPR, it did not diminish the importance of the Surveillance and Utilization Review *(*SUR) function. It intended to provide the States with greater flexibility in performing the SUR function.

One portion of the SPR had mandated specific numbers of utilization reviews to be opened in order to prevent, detect, and control fraud and abuse. Program integrity (PI) staff supported by the Surveillance and Utilization Review Subsystem (SURS) of the MMIS traditionally conducted these reviews. Although the SPR requirement has been deleted, Section 4753 requires each State to operate a system that is "adequate to provide efficient, economical, and effective administration" of its respective Medicaid State plan.

States are no longer required to conduct a certain number of utilization reviews but are still responsible for ensuring the "proper and efficient administration" of the Medicaid program. This requirement is stated in section 1903(a) of the Social Security Act. The utilization control requirement is found at 1902(a)(30)(A) and 42 Code of Federal Regulations (CFR) Part 456. With these facts in mind, States have requested guidance in conducting Medicaid utilization reviews.

To respond to this request for assistance, HCFA joined with State staff to form a State/HCFA workgroup to provide guidance in utilization review. Also included in this document, as Appendix A, are "best practices" used by States. These are shared as a source for States seeking ways to improve the SUR function.

<u>INTRODUCTION</u>

This document is the culmination of efforts by the State/HCFA workgroup staff. It contains information provided by SUR and PI staffs from a number of States, information gathered from approximately half the States, best practices, and some insights from HCFA- sponsored seminars on fraud and abuse in Medicaid. The document provides guidance and best practices that were developed to assist States in performing their SUR functions in accordance with federal regulations

at 42 CFR Part 433, <u>State Fiscal Administration</u> (specifically Subpart C), 42 CFR Part 455, <u>Program Integrity: Medicaid</u> (specifically '455.1), and 42 CFR Part 456, <u>Utilization Control</u> (specifically '456.1).

These recommendations are not all-inclusive and are intended only to give States guidance. States still are expected to continue to comply with the federal regulations governing the operation of an MMIS.

REGULATORY BASIS FOR DOING BUSINESS

These guidelines are developed in compliance with federal regulations at 42 CFR Part 433, <u>State Fiscal Administration</u> (specifically Subpart C), 42 CFR Part 455, <u>Program Integrity:Medicaid</u> (specifically '455.1), and 42 CFR Part 456, <u>Utilization Control</u> (specifically '456.1).

Section 42 CFR Part 433, Subpart C, <u>Mechanized Claims Processing and Information Retrieval Systems</u> addresses the issues of:

- providing federal financial participation (FFP) in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems;

- defining a "mechanized claims processing and information retrieval system" used to process claims and to retrieve and produce service utilization and management information required for program administration and audit purposes; and

- required subsystems, i.e., Surveillance and Utilization Review Subsystems.

Section 42 CFR Part 455, <u>Program Integrity: Medicaid</u> addresses the requirements of a State fraud detection and investigation program and for disclosure of information on ownership and control.

Section 42 CFR Part 456, <u>Utilization Control</u> addresses the requirements concerning control of the utilization of Medicaid services.

NEW WAYS OF DOING BUSINESS

Case Development and Periodic Review

States are now free to concentrate on developing more substantive cases since Congress eliminated the SPR requirements. This has allowed for additional time to be spent on developing the various aspects of the case. For example, States can expand on provider

education rather than concentrating on monetary recoveries. In addition, States now have an opportunity to use SURS for identifying Medicaid program policy inconsistencies. States may develop their own formulas, procedures, and/or methods for selecting providers and recipients to review. States may assess their own performance to measure progress toward objectives.

No two Medicaid programs are alike. Consequently, there are a variety of approaches to payment review processes. Many States rely solely on the SURS to generate their cases. Other States may utilize fraud and abuse detection systems. Others utilize a combination of processes and systems. While some States pull convenience samples based on billing patterns, other States use statistically-valid sampling with extrapolation that is a more formal approach.

One State uses the factors and formulas published in the last SPR manual (before SPR was eliminated) as the basis for opening cases in the review of noninstitutional providers and recipients. The State advocates the development of cases targeted towards: educating the average provider who is having billing problems; recovering overpayments; identifying weaknesses in policies where clarification or new policy is needed; and referring cases of reasonable suspicion to the Medicaid Fraud Control Unit (MFCU).

Several States have explored pilot programs that would involve the use of fraud and abuse detection software such as those offered by many vendors in the market place. The rationale behind projects such as these is to target billing patterns that are far outside the accepted billing practices in terms of defined policies. These projects could also help to identify larger problems in the provider universe that might otherwise be missed. One State opted not to use vendor technology. The State organized a multi-agency, cross-functional workgroup whose task was to generate a list of scams in order of severity and to test and implement new algorithms.

Another State contracted for fraud and abuse detection and recovery on a contingency basis. As a result of the contract, the State has initiated collections close to $6 million and has made a number of recommendations to policy staff, which may result in additional savings. The State is in the process of reviewing additional provider groups, which have not been reviewed. Other examples which utilize new fraud detection techniques include: trend analysis that focuses on the detection of computerized billing schemes; a spike billing detection system; a search capability to identify common addresses from different providers; and the use of intersect reports to identify kickback schemes.

When reviewing institutional providers, States may develop their own methodology or use the services of a Peer Review Organization (PRO). If using a PRO, contractual language should outline the functions and responsibilities of the PRO in a utilization review program.

Through the use of new and innovative techniques for doing business, States may be able to more effectively utilize staff, as well as, state of the art software and hardware.

Studies Can be Useful Tools for Improvement

Some States have undertaken studies in an attempt to both quantify the amount of fraud and abuse in their program and to verify the payment accuracy of their claims payment process.

Establishing a Baseline

In order to begin to measure progress in the control of fraud and abuse, many States are attempting to establish a baseline measure for their own particular program. One method is to conduct measurement studies of overpayment rates. Studies can be used to get a general idea of where a State is at a certain point in time and what areas it needs to target for fraud and abuse control.

One State conducts a biennial measurement that entails the following analyses: medical records reviews; client interviews; reviews of recent client medical history; and validation of the diagnoses. The first study, completed in 1997, revealed that more than 13 percent of the Medicaid services reimbursed were paid in error, while, overall, more than 95 percent of the payments were accurately made.

Other States use various measurement tools to measure their progress in controlling fraud and abuse. One such tool is the use of statistically-valid random sampling with extrapolation for provider reviews. This tool can be used for generalized investigation in a specific area or in the development of postpayment reviews. The results (i.e., error rates, overpayment totals, etc.) can be used to show trends.

Payment Accuracy

A random sample of claims is collected, and then each claim is thoroughly reviewed. The review is conducted in order to provide answers to the following questions:

1.   Did the claims payment system work correctly?
2.   Is the claim supported by medical documentation (through review of a medical record)?
3.   Do beneficiary interviews and phone calls support the provision of the service?

One State conducted a measurement study that revealed a payment accuracy rate of more than 95 percent. The study was based on interviews with clients,

examining patient histories and medical records, and validating the diagnoses. The study further suggested that about $113 million be misspent in its fee-for-service (FFS) component. One glaring finding highlighted a provider who could not substantiate any of his services.

These studies are valuable program aids since they point out areas where limited funds and staff can best be used for improvement.

Computer Systems

States may use traditional SURS in new ways or may want to add newer technologies to assist SUR analysts in performing their functions. This section attempts to provide suggestions for using the traditional tools. In addition, it describes some newer technologies for performing traditional, as well as, customized SUR functions.

There are several vendors that provide software products or systems that do profiling, drill down, ad hoc reporting, exception processing, trend analysis, etc. on providers.

Data Warehousing

Mainframe SUR subsystems generate vast amounts of electronic data which is often difficult and labor intensive to access and analyze. Therefore, many States are moving in the direction of data warehousing.

Data warehousing has now become a popular medium for analytically oriented systems. The key feature of a data warehouse is that data from a transaction-driven operational system like MMIS is replicated into a relational database that is designed for ready access to large amounts of data outside of the MMIS. In this way, processing of complex reporting queries by State staff does not impact the MMIS. A data warehouse is targeted towards retrieval of data in the aggregate while MMIS is concentrated towards updating the speed at the individual record level.

States that are using data warehouses have found them attractive in that the data warehouse can be customized to fit their analytical needs. Data can be integrated from multiple sources or formats and key variables can be standardized. Links can be developed from MMIS to the warehouse. The warehouse can be designed to add methodologies to study selected variables. States can include a quality assurance module, so they can accurately reflect costs, data validity and accuracy, and service delivery statistics.

Enhancement of SUR Subsystems

6

States are encouraged to enhance their SURS so that SUR staff can readily identify and isolate suspicious patterns of practice. SURS can retrieve current data that can then be manipulated with PC software to analyze aberrant patterns. Use of exception profiling as a starting point for case development is a viable technique in the detection and control of fraud and abuse. Special reports derived from SURS often target questionable billing practices.

One State has made periodic enhancements to its 1981 certified SURS and has fine-tuned the Control File to profile the more aberrant practices. SUR staff works with MMIS staff to create special subfiles of information to be downloaded from the mainframe into a PC spreadsheet file. This way staff can manipulate the data in a number of ways. While not as effective as a PC based SUR system or a decision support system (DSS), it still can get to the heart of the matter quicker than a review of 100 percent of data.

Decision Support Systems (DSS)

States may also use any of the DSS relational database packages on the market. These systems offer a multitude of functions for the SUR user. Some of these functions are:

- flexible and easy access to several years of paid claims history data;
- ability to query promptly and multidimensional;
- eliminates the need for computer programmers to produce queries and reports;
- prompt output of the requested data;
- ability to query real time data; and
- access to statistical summaries, trending patterns, and profiling.

Front line staff can "point and click" queries, request reports at the desktop, and preview the output. Requests can be aborted in preview mode if the query produces an ineffective result, thus saving the use of computer processing time. Most reports are created the same day as the request or query is made. Various managers within the State Medicaid agency, not just the SUR staff, can use ad hoc reporting functions. Many States use ad hoc reports in policy and program planning, in developing a budget, in answering legislative requests, and in monitoring operational functions. States can design or modify a system to meet their needs and budget since the cost of a DSS is related to its design.

Client Server PC Based SURS

A PC based system may be a viable alternative for States that choose not to

modify an existing SURS. These packages can be operated through a dedicated network that provides a place to keep the extensive SURS data, to process SURS runs, and to store reports. Client server PC based systems are more "user friendly" than traditional mainframe SURS, (e.g., using "point and click" technology in a system capable of performing several functions at the same time).

The PC based systems do not compete for mainframe resource*s* with other systems within the MMIS as the traditional mainframe SURS does. PC based systems can run profiles daily on current information while the mainframe SURS Control File runs quarterly reports and profiles using claims information up to 15 months old. States can build or procure the degree of sophistication in a PC based software package that meets their needs and administrative budget. These systems are software packages and are not typically as costly as DSSs.

Fraud and Abuse Detection Systems

Another system option is the purchase of fraud and abuse detection systems. The market for these tools has increased significantly in the last few years. Companies offer different packages which include the following desired component for a state of the art fraud and abuse detection system: ability to detect fraud and abuse up front; or, at least before payment is made. These packages use statistical and database techniques to analyze claims payment data looking for patterns that would suggest abuse.

 One technique is to search for relationships between providers and recipients that would indicate excessive contact, and, thus likelihood of "rings" or at least abusive payments. These packages incorporate a broad range of algorithms to detect higher levels of fraud scams. This is a step beyond profiling.   Additionally, they include a broad range of analytic tools such as statistical summaries, comparisons, ratios, neural networks, and a variety of statistical methodologies that can be applied to a broad range of situations.

Other States have taken approaches in addition to the use of technology. One State established a fraud detection workgroup composed of staff members from the Medicaid agency and the Office of the Inspector General (OIG). Together they develop fraud detection tools and ideas gathered from a multidimensional workgroup.

Another State has contracted with a vendor for the detection and recovery of overpayments on a contingency basis (there is neither cost nor risk to the State). The vendor cannot collect overpayments without authorization. The vendor's profit

is dependent on the assumption that there is an abundance of easy to recover overpayments.

States use differing techniques to analyze data looking for patterns which may indicate possible abuse. Some examples include:

- In terms of recipient fraud, one State organized an information exchange with 87 State and federal agencies. The objective was to identify inconsistencies in information given by recipients to several agencies.

- Another State developed a mechanism to identify common addresses for different providers. The State was looking for fraud from third parties and for checks from multiple providers going into a common bank account.

- One other State designed a report to look for kickbacks, particularly one provider in a group billing as if rendering the services. Other providers may be referring patients/cases to this same provider in return for kickbacks.

Modification of Existing MMIS (Outside of SUR Subsystem)

One other option is to modify the existing MMIS to produce reports within MMIS but outside of SURS that identify suspected abuse. Techniques used in several States include developing reports to identify higher than average or "spike" payments going to providers, as well as, to identify marked increases in the number of small payments going to the same provider. Another computer program typically looks for the newly enrolled provider who claims large payments quickly and is gone before exception processing would detect it. A summary of the "spike" payment report is as follows:

There have been cases of providers across the country that developed schemes to bill several thousands of dollars in claims in a short period of time without providing any services. Some of these schemes resulted in over hundreds of thousands of dollars, if not millions of dollars, going out by electronic transfer payments. By using this report, a State identified a check for $7.7 million that would have been sent to a provider by mistake. In many of these cases, if the Medicaid or Medicare programs were not reviewing weekly payments, it would go undetected for several months.

In summary, States could create and implement the use of a weekly payment report that would help protect from the "hit and run" providers. A set payment limit or maximum payment limit for each provider type should be established.

Additionally, the report could identify at least the provider number, billing provider, servicing provider, provider type, beginning date of eligibility as a provider. When a provider's payment goes over the set amount allowed, the provider would appear on the spike report. Each week before payments are released, PI/SUR staff would review this report, and stop payments and/or start an investigation if the report indicates problems.

New methods are needed to assure control and accountability of managed care organizations (MCO) that are providing a new way of delivering health care service. Requirements for and definitions of encounter data should be specifically described via State managed care (MC) contracts. The capture, reporting, and analysis of this data should be in accordance with contractual language. The quality and standardization of the data collected from the various plans and providers are of great significance. States also need a mechanism to monitor compliance with the provisions of MC contracts.

NEW APPLICATIONS FOR THE SUR FUNCTION

The implementation and expansion of MC in State health care programs have forced changes in the performance of utilization control and PI. The financial incentive for abuse of the Medicaid program in FFS is for overutilization of services to increase payments; whereas in MC, it changes to underutilization of service. The financial incentive for the MCOs or individual providers who are primary care case managers (PCCM) is to provide less service since their payments are not based on the number of services provided. This has also changed the focus of utilization review since service providers are now motivated to withhold services (and thus reduce costs) rather than to overutilize them as in traditional FFS.

Since State MC contracts require fraud and abuse provisions, SUR units would be invaluable in providing the State with the appropriate language to address fraud and abuse prevention, detection, and control in MC. This component should address the issue of underutilization. Contracts should also protect States from MCO network provider noncompliance and fraudulent claims. They should also contain instructions on how MCO employees, providers, and patients should report fraud and abuse.

A variation of MC in some States is "noncontractual" enrollment agreements with physicians. These agreements provide for a core set of services along with a FFS component. Since these providers also need to be monitored, the States could assign the SUR units the responsibility for monitoring the performance of these providers using SUR tools.

In order to have "two sets of eyes" while performing the waiver review of Medicaid MC, federal and State staff may want to consider working together to perform the review. This uses the

expertise found in both the federal and State agency to perform a more powerful review. State SUR staff, along with other State agency staff, can join with HCFA regional office staff in conducting reviews of the States' MC plans. These reviews would be part of MC waiver reviews and could involve onsite visits to MC plans. Several teams could look at various aspects of the services provided by the plans. Several days could be spent at each plan looking at medical records, interviewing plan staff, and reviewing plan policies and processes.

Additionally, the teams could look at processes such as provider enrollment and credentialing, complaints and grievances, and utilization review. The SUR manager could serve as a team member to review provider processes and utilization review. Since many plans pay their providers on a FFS basis, traditional utilization review expertise would be helpful in reviewing the efforts of the plans to detect and prevent abuse. Before the visits, State and HCFA staff could be involved in detailed planning to develop a review process. After the visits, both State and HCFA staff could be involved in writing a report that is presented to the plans.

The results of reviews should be used to improve MC systems. In order to prevent the same fraud and abuse from continuing, this information should be incorporated into a MC quality assessment and improvement system/process. SUR staff can assist in obtaining this major goal by partnering with the State's MC quality improvement staff.

The following are some examples of how PI/SUR units can enhance the work of the PRO and/or other review staff in States with MC, and, therefore, help to make the Medicaid program more effective in the FFS and/or MC environment.

- The PI unit could team with the MFCU to train the PRO or other MC review staff in the detection of fraud and abuse activities most commonly found in MC. Contact names could be exchanged to provide for investigative assistance or policy clarifications.

- The PI unit could review a selected number of completed PRO cases to provide a check and balance of the PRO's case resolutions or actions.

- A report could be created to profile providers within the MC program to monitor provider referrals. The objective would be to detect and subsequently deter practitioners from claiming the capitated case management fee without providing services.

- PI/SUR units can work closely with their department's MC unit quality assurance staff to make and accept referrals when quality of care issues are identified in reviews. Sharing quality issues/referrals is helpful since many providers are involved in both Medicaid MC plans and

fee-for-service plans. Quality issues in one area will most likely arise in the other as well.

It is important for the highest echelons of management to understand that fraud and abuse do take place in the MC setting and that it is not just the MCO's problem. It becomes the State's problem: when its citizens are not getting the services which the State has paid for; when the State has to pay higher capitation rates; when an MCO goes bankrupt leaving a void for access to service; or any number of other scenarios which affect the health of its citizens. The following are just a few examples of how fraud and abuse occur in the MC setting:

- Fraudulent subcontractors create a phantom provider to bill for providing Medicaid services.

- False enrollee registrations are created by using fictitious patient names.

- Some MCOs use improper enrollment practices in order to steer the healthier individuals their way.

- MCOs hire an insufficient number of providers in order to provide the clients access to the specific medical care that the plan promotes.

SHARING NEW WAYS WITH OTHER STATES

SUR/PI units have made great progress towards correcting inefficiencies in the Medicaid program and relating to the MMIS. These corrections sometimes involve effecting changes in policy and/or automated processes, e.g., systems edits do not always relate directly to fraud and abuse. Other areas in which the SUR/PI units' invaluable expertise has assisted in the administration of the Medicaid program include:

- Postpayment reviews revealed that a certain drug code was being used incorrectly, but not necessarily fraudulently. After further investigation and discussions with the program policy writers, policy was rewritten to clarify and eliminate this problem.

- After conducting reviews of recipient utilization, the SUR unit recognized the need to more formally deal with instances of pain management that relate to quality of care. These reviews indicated that physicians may be over prescribing to patients for pain management. Upon reviewing these cases with a physician advisory board, the State decided to offer assistance in pain management. This assistance was provided by publishing pain management guidelines, sending a copy of these guidelines to identified physicians dealing with individual patients, and advising the identified physicians to refer the patients to a pain management consultant made available through the State. In order to implement this policy, the State had to change its previous coverage restriction on "pain management." Besides producing better policy, it provided an opportunity for the State to work with physicians on pain management. The pain

management the State now covers includes services such as physician visits and lab tests to monitor drug levels.

- Another SUR review found that therapy units were being billed on a per 15 minutes basis rather than on a per visit basis. Staff worked to have the following published in a provider manual bulletin**:** "Therapy codes should be billed as one unit equals one visit unless the description of the code specifies the unit."

- The result of a SUR review of a pharmacy, which was incorrectly billing total parenteral nutrition (TPN) and intravenous (IV) pump rentals, changed the prior authorization policy for TPN. As a result of this change, when providers are given prior authorization to bill for TPN, the number of units authorized is limited to one per 24 hours since TPN is typically dispensed with one bag lasting 24 hours. Besides helping to change policy, the SUR unit identified almost $750,000 in overpayments.

- A SURS records review performed by the SUR unit revealed that a speech therapist was billing the Medicaid program using incorrect codes. The speech therapist was enrolled to provide services only to head-injured beneficiaries receiving home and community-based services through a waiver. The therapist was authorized to bill the Medicaid program using a special code. The automated claims system files were examined, and this revealed that no automated process prevented the provider from billing these "non-waiver" codes. System changes were quickly made to prevent this provider from continuing to bill these codes. In addition to alerting the system staff to the problem, the SUR unit identified over $190,000 in overpayments.

States are encouraged to interact with other States and share information in terms of how they conduct the SUR function, how much they recover, and the size of their SUR unit. Analysis of historical data may eventually yield a formula that will assist managers in determining the staffing needs of the SUR unit.

CONCLUSION

In conclusion, this document is intended to provide guidance for the vital Medicaid management functions of utilization review and PI.   It has also provided some examples of other less obvious functional responsibilities that these units have. With the relaxation of federal requirements, States have more flexibility to design a system for the prevention, detection, and control of fraud and abuse which specifically meets their need. This discussion of the underlying federal requirements, the new ways of using traditional mainframes, the availability of relational databases and other software applications, the influence of MC, and sharing ideas across State lines is intended to create a handbook for a new era.

APPENDIX A
BEST PRACTICES SHARED BY THE STATES

BILLING PRACTICES

-   Certified registered nurse practitioner (CRNA) providers were billing incorrectly with the same pattern. Anesthesia units were set for 15 minutes. They were billing as if the units were for one minute. All anesthesia providers billing for more than 16 units per claim were identified. Eighty providers were selected for review and each provider was sent a letter extending an opportunity to perform a self audit for a five-year period. There was a 99 percent participation rate. Approximately $531,000 was recovered within 4 months.

-   A report on Evaluation and Management (E&M) codes was created to use in a time study. Approximate time values were assigned using the Current Procedural Terminology (CPT) Book. The report identified the minutes per day each provider was billing. 60 to determine the total hours divided the total minutes billed. The top providers were selected and the review was expanded. One of the providers was billing for as much as 46 hours in one day. Two of these providers have been referred to the MFCU, and mechanisms for other referrals are being developed. The estimated loss to the State Medicaid program is $300,000.

-   SUR units produce special reports on issues that arise out of an individual provider or beneficiary review, i.e., compiling runs on a specific provider type for specific procedure codes based on problems found that appear to be a pattern and looking at all provider billings for that code to find discrepancies.

-   The factors published in the last SPR manual (before SPR was eliminated) are used as the basis for opening cases in the review of noninstitutional providers and recipients. Emphasis is on the development of quality cases more than on meeting the number of case review requirements. Even though the old formulas are used for selecting the number of cases to review, the first priority is developing quality cases.

    Periodic enhancements were made to the certified SURS, as well as, fine tuning the Control File to profile the more aberrant practices. SUR staff works with MMIS staff to download special files, i.e., requesting that a subfile of information be downloaded from the mainframe into a PC spreadsheet file. This allows staff to manipulate the data in a number of ways. While not as effective as a PC based SURS or a DSS, it still can get to the heart of the matter quicker than a review of 100 percent of data.

Active providers and recipients are defined as those having had one claim filed within the last year. Cases are generated from the SURS Control File Exception Profiles, referrals from the OIG, HCFA, and law enforcement entities, and complaints from both the general public and in-house staff.

A division of investigations, within one PI unit, receives all cases and complaints of alleged fraud and abuse in the Medicaid program. The division is staffed with two commissioned police officers who conduct preliminary investigations. They work cases jointly with the MFCU, OIG, local law enforcement, US Attorney, Drug Enforcement Agency (DEA), local solicitors, State law enforcement narcotics units, and the Federal Bureau of Investigations (FBI) Health Care Fraud Task Force.

A provider letter with an emphasis on education was developed. The new letter of determination has become more professional with "findings" identified, references to program guidelines, and more attention to education of the provider through a narrative description of proper billing practices. The format used lists the findings, identifies the manual page where the program policy is stated, and gives recommendations on how to correct the problem (e.g., what the proper code is). This has been received positively in the provider community. It requires staff to do a lot more work than just listing discrepancies and asking for money, and no one can ever say the provider was never told how to bill appropriately. If the provider demonstrates deliberate indifference despite the lengthy letters of determination, a referral to the MFCU for fraud investigation is made.

- Staff in the State's health department, who deal with audits, investigations and medical review, noted a marked increase in the number of claim submissions for certain diagnostic tests and procedures by Medicaid physician providers. Additional analysis focused on 15 noninvasive services. Using information from three of the State's abuse detection systems, one of which is SURS, individual family and/or general practice providers were identified who were being paid for any, or a combination, of these services. These providers' claims patterns far exceeded the norm for their peer group in terms of frequency, quantity, and length of treatment.

A comparison of the State's program payments for the last six months of the last two fiscal years identified an approximate 50 percent increase, with a potential for more than $33.5 million in reimbursements for these tests if claims continued to increase as projected. Existing State Medicaid sanctions, relying on post-service post-payment activities, were not appropriate devices to address this problem. This is because the program requires prior authorization for specific services for which all providers, who bill for the services, must obtain approval authorizing treatment before providing the service. The specific noninvasive tests would be appropriate for some specialists, and occasionally, by some family/general practitioners. However, requiring preapproval authorization for treatment provided by all providers would not be a workable solution. The pre-service, pre-payment

sanction of prior authorization for individual providers, for selected services, was the most feasible approach. The State believed that the majority of the services claimed were either unnecessary or not being rendered. An individual prior authorization (PA) form was devised, and a system was developed to accommodate the process. A pilot study of seven providers was initiated with the following results: six PAs were submitted and all were denied; cost savings of $5.9 million were identified for the seven providers; and the PA system is now a routine sanction tool which can be used for desk reviews and field audits.

PAYMENTS

- A report was created to help protect from hit and run providers. This weekly report was created to review the weekly payments to providers before the checks or electronic transfers are sent out. A payment limit for each provider type was established. When a payment goes over this amount, that provider's name will print on the weekly report. The report lists the provider number, billing provider, servicing provider, provider type, beginning date of eligibility, payment amount, and maximum payment limit. Through the use of this report, millions of dollars have been identified that would have been sent to providers by mistake.

- A Medicaid contractor has worked with the State's health department to help to overcome the fraudulent use of the State's Medicaid program by reviewing more than 1,000 providers per year with potential fraud and abuse situations. The Medicaid contractor is presently working to develop a modern SUR system that will continue this track record of using SUR to improve the efficiency of Medicaid expenditures in the State. This system will meet all HCFA requirements for certification as an MMIS SURS. A team consisting of the State's health department, the Medicaid contractor, the Health and Human Services Commission, and SURS industry experts are working together to develop this enhanced SURS. The SURS will be designed to handle the review of services in the insured program, MC, and special programs area. The SURS will provide the following benefits over the existing system: enhanced peer grouping and profiling; enhanced exception processing; rapid generation of claim samples; and a windows-based environment.

  One enhancement of the new system, which will assist SURS in fraud and abuse detection, is the Ad Hoc Query Platform (AHQP) which will be used for report generation. The AHQP will allow users to define and initiate queries and reports via a graphical user interface (GUI). The AHQP allows for more flexible reporting capabilities and shorter time frames for report generation. It is also available to the end user via an easy to use browser-based interface. In early FY2000, the SURS data will be available on the AHQP to SURS end users including the Attorney General's Office, the Health and Human Services Commission, and the Department of Health.

- Using a proactive approach for weeding out the bad providers, before the system suffers big losses**,** a report was created to identify all new providers added for the month. A sample of providers is selected and their location is verified. If they have started billing, a sample of claims is selected, and a visit is made when staff is in the area on another case. The element of surprise gives some of them a sense of not knowing when we will be back or what we may be looking at. One pharmacy, located several miles from any city, was found to be physically located in a shed behind a house. The same provider also had a durable medical equipment site set up in the house.

QUALITY OF CARE

- Referrals are made to appropriate licensing boards when medical professionals are suspected of not meeting the requirements of their license. Referrals have been made to physician, nursing, pharmacy, and dental licensing boards. These referrals also involve following up with the respective licensing boards in order to provide copies of records giving examples of the basis for the concerns which prompt the referrals in the first place. Several referrals have resulted in actions such as requiring provider training and asserting additional stipulations on the provider. Referrals are also made to enforcement agencies, such as the DEA, of "impaired physicians" through a program run by the State's medical society and the State's drug utilization review board. Additionally, concerns found during nursing facility reviews are forwarded to the State's survey and certification agency.

- It was found that a physician was having problems tracking the medications (especially narcotics) he was prescribing. This caused the SUR unit to be concerned about his patients. This problem was also a concern for the pharmacist who filled most of his prescriptions. Upon being reviewed and informed about this problem, the physician worked with the pharmacist to develop and use a form for each prescription that was written to better track medications. Follow-up reviews, after education has been given to providers, sometimes reveals noticeable improvement in the way a provider practices.

- The SUR unit performs recipient utilization reviews looking for possible "lock-in" cases. The unit works with recipients to let them know if there are concerns about the way that they are using medications and services. Mainly this is done through letters and phone calls from a lock-in coordinator who works as part of the utilization management unit.

- The SUR unit is slated to be represented on the State's MC quality improvement committee once it is established. The objective of this is to be able to share issues of

concern with physicians to obtain their guidance in handling these issues, particularly in the quality assurance/quality improvement area.

- In reviews of home health agencies, monies are recouped when services are found to be of substandard quality. The following are a few examples:

  - After a review of a particular home health agency, a referral was made to the State survey and certification agency with concerns about the agency's license. Specifically cited was an order that the agency had to "straight catheterize a consumer three times per day. Nursing documentation indicated that between 9/17 and 9/30 the consumer was straight cathed only two times per day except for two occasions. There was no documentation that indicated the consumer refused the procedure. It was noted numerous times that the consumer continued to have problems with UTI's (urinary tract infections)."

  - A home health agency review cited numerous examples of error in the type and amount of insulin medication given. One such example is that nurses were giving 30 units of insulin @ 5P instead of 25 units as ordered. Nurses were also not adhering to sliding scale insulin instructions. Another example of poor nursing was that in March the agency routinely began providing skilled nursing visits three times per day rather than four times a day as ordered. However, no change in orders was noted. Monthly case notes done for April by nursing staff state "increased skilled nursing visits to three times a day." This was further demonstration that documentation by nursing staff was inadequate and confusing.

  - Another review found that a home health agency's, "Skilled nursing visits were reimbursed for assessment, urinary catheter care, and medication assistance. A total time of 50 minutes was documented during the 12/17 morning visit. The narrative states "Vancomycin 100 mg infused per HL (heparin lock) L (left) Hand c/0 generalized weakness." The chief complaint of weakness is not addressed." According to Facts and Comparisons, a minimum of 60 minutes is required to infuse the vancomycin. The concern was that the nurse took only 50 minutes to do a 60 minute procedure and did not seem to address the complaint the patient had of weakness.

RECIPIENT FRAUD

- A centralized lock-in program was established, and MCO activities were coordinated to ensure that recipients who abuse services are identified. The State helped the MCO set up a profiling system similar to FFS lock-in to identify their recipients who abuse services.

- An on-line drug utilization review program has been highly successful in reducing prescription medication overutilization by Medicaid recipients. The usual scenario is that the dispensing pharmacist receives an early "refill" or "duplicative medication warning" and confronts the patient. The client usually backs down or remembers the other prescription. However, pharmacies can at times be lax in their oversight and override the alert. Regardless of this slight possibility, significant dollars are saved in turning away these questionable prescriptions.

  Clients who defraud the Medicaid program are forging prescriptions for highly prescribed expensive medications. The drugs then pass through a sophisticated underworld drug distribution system and sometimes wind up as part of the inventory of unscrupulous pharmacies or are diverted overseas. This results in a serious public health issue for everyone.

  The State's utilization review staff (nurses and pharmacists) in the health department has been successful in developing criteria for detection of forged prescriptions. Analysts, for example, "force except", using recipient SURS runs, the drug and medical claims history for any client using five or more pharmacies in a one-month period. Claims review experience has shown that most individuals presenting forged prescriptions try to go to many pharmacies obtaining two or three prescriptions from each provider. In reviewing the claims of these "excepted" recipients, staff attempt to match the medications obtained with the recipient's diagnoses using claims history, as well as, the prescriber's identification with the provider's identification that billed for visits.

  After the State contacts the pharmacy, the prescriber is contacted to verify the prescription's authenticity. If the prescription was forged, the State attempts to obtain more information from the prescribers such as their specialty, where they are employed, and a copy of their legitimate signature. The State's MMIS has a report that targets and obtains the claims details of all recipients having received prescriptions from a selected prescriber. If provider collusion is suspected, referrals are made to PI/provider SUR staff.

  Another drug utilization review program generates 300 to 400 drug utilization review board provider profiles and response forms monthly. About 20 percent of these are returned with, "Not My Patient" responses. These clients' medical histories are reviewed. Often these are the result of a pharmacy billing error, i.e., wrong physician identification number as the prescriber, or the recipient stole the blanks and wrote their own orders. The appropriateness of all services obtained is still verified. This is a complicated process since

many of these forged prescriptions are written on clinic blanks. The facilities are contacted, and it is frequently determined that the prescriber in question has no affiliation with the clinic. When this type of information is confirmed, it is added to the alpha prescriber file.

The department publishes a monthly provider update list of sanctioned providers and publishes a Medicaid newsletter. The recipient review unit often submits short articles encouraging pharmacy providers to contact the unit when they encounter clients with forged prescriptions or questionable combinations of medications.   Physicians are also encouraged to contact the unit when they lose prescription blanks or name stamps. Pharmacies are encouraged to refer suspicious clients whenever they are contacted.