

case study:

Program Integrity Audit



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THE CLIENT

North Carolina Division of Medical Assistance (NC DMA),
Program Integrity Office

THE PROJECT

Post-payment Medicaid claims review, February 2010 - present

THE CHALLENGE

In 2010, NC DMA began a partnership with PCG to expand and improve upon its program integrity efforts in behavioral health and other home and community-based services. DMA had a backlog of hundreds of complaints against providers that had not been investigated. This backlog was comprised of providers suspected to have received overpayments of greater than \$100 million. Short on resources, DMA turned to PCG to expand the productivity of its program integrity efforts by improving technology, implementing operational efficiencies, and providing additional staff.

DMA investigates leads when clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activities. Leads are generated through phone calls received within the DMA Program Integrity Office regarding potentially abusive billing practices or, more recently, through the state's third-party fraud and abuse detection tool. Once these leads are generated, a thorough follow-up investigation is necessary to adjudicate the complaint and ensure that the Medicaid program has not overpaid for services rendered, also allowing providers ample opportunities to respond with additional supporting documentation to validate their claims.

The primary purpose of the PCG Health contract is to supply clinical and administrative resources to follow up on these leads. The benefits of the project are to (1) allow providers to implement and maintain compliant billing practices; (2) remove non-compliant providers from the Medicaid program; (3) recover inappropriate payments via provider offset; and (4) provide ongoing and progressive cost savings by reducing non-compliant claims submitted to Medicaid.

THE PCG APPROACH

PCG Health designed, developed, implemented, and operates a process for performing clinical reviews of provider-submitted claims for home and community-based services in NC Medicaid.

PCG follows a standardized audit protocol in line with the policies and procedures of the state. Every PCG audit is initiated by an allegation of fraud and/or abuse received at DMA's Office of Program Integrity. PCG's audit methodology, including the criteria for all administrative and clinical overpayment determinations and the use of extrapolation, was developed and defined by DMA. PCG executes its audits as prescribed by DMA using a Web-accessible case tracking system to ensure transparency, accountability, and quality assurance by centrally organizing all case data, decisions, and documentation for real-time DMA inspection and quality assurance.

THE RESULTS

To date, some of the key results of this engagement include

- \$350+ million in provider recoupments issued since project inception. PCG has completed more than 1,400 Behavioral Health (BH), Personal Care Service (PCS), Dental, Community Alternatives Program for Disabled Adults and Children (CAP-DA/C), and Home Infusion Therapy (HIT) provider reviews and generated more than \$350 million in provider recoupment notices. The North Carolina Department of Health and Human Services (DHHS) has generated nearly \$8 million in recoveries over the project to date, with millions in anticipated recoveries as future provider payments are offset.

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- PCG has submitted \$80 million in accounts receivables setups to DMA since 2011. DMA has collected nearly \$8 million from providers audited by PCG since 2011. Following the expiration of their due process rights, providers identified as having been overpaid by the state's Medicaid program are set up so that *future* payments are offset until their balance is paid.
- PCG's reviews have resulted in greater than \$165 million in annual DMA cost avoidance. Audited providers have submitted an average of \$128,000 less in Medicaid claims in the year following a PCG audit. Because home and community-based services (HCBS) require less investment in capital and staff than acute care, HCBS providers regularly choose to close their Medicaid ID without repayment when faced with a recoupment; to date, more than 150 providers have chosen to cease billing the Medicaid program rather than pay back the state.
- 47% compliance rate across all providers audited. PCG has identified significant compliance issues related to non-credentialed staff; inconsistencies between plans of care, health assessment, and the services delivered; and inadequate documentation to support the time billed. To date, the overall compliance rate among the providers is 47% as compared to required DMA policies and standards.
- 95% of findings upheld at appeal upon a final review of all documentation. PCG has participated in more than 700 DHHS reconsiderations. Approximately 350 cases are in the DHHS appeal process with a total case value of \$60 million. The DMA/PCG project team currently participates in nearly 30 appeals per month. In these appeals, significant additional documentation – which had previously been requested multiple times – is submitted and reviewed.
- More than 1,400 provider audits have been completed. PCG has completed reviews of 1,400 providers, including Behavioral Health, Personal Care Services, Community Alternatives Program for Children/ Disabled Adults (CAP C/DA), Dental, Ambulance and Durable Medical Equipment (DME) providers.
- 73 onsite Behavioral Health reviews have been completed. PCG has completed 73 onsite Behavioral Health reviews to date and has issued 73 Tentative Notices of Overpayment (TNOs) totaling \$14.9 million.
- 298 desk reviews of Behavioral Health providers have been completed. PCG has completed 298 Behavioral Health desk reviews to date and has validated \$175.8 million in provider overpayments.
- PCG has referred \$27 million in annual billing to the NC Attorney General's office for investigation. PCG audits have resulted in 24 providers, accounting for \$27 million in annual Medicaid billing, being referred to the North Carolina Attorney General's *Medicaid Investigations Unit (MIU)* for investigation.
- PCG analytics identified 480 providers exhibiting suspicious billing patterns. PCG validated \$11.7 million in provider overpayments through the use of health claims analytics and sent 480 recoupment letters to providers across the state.

