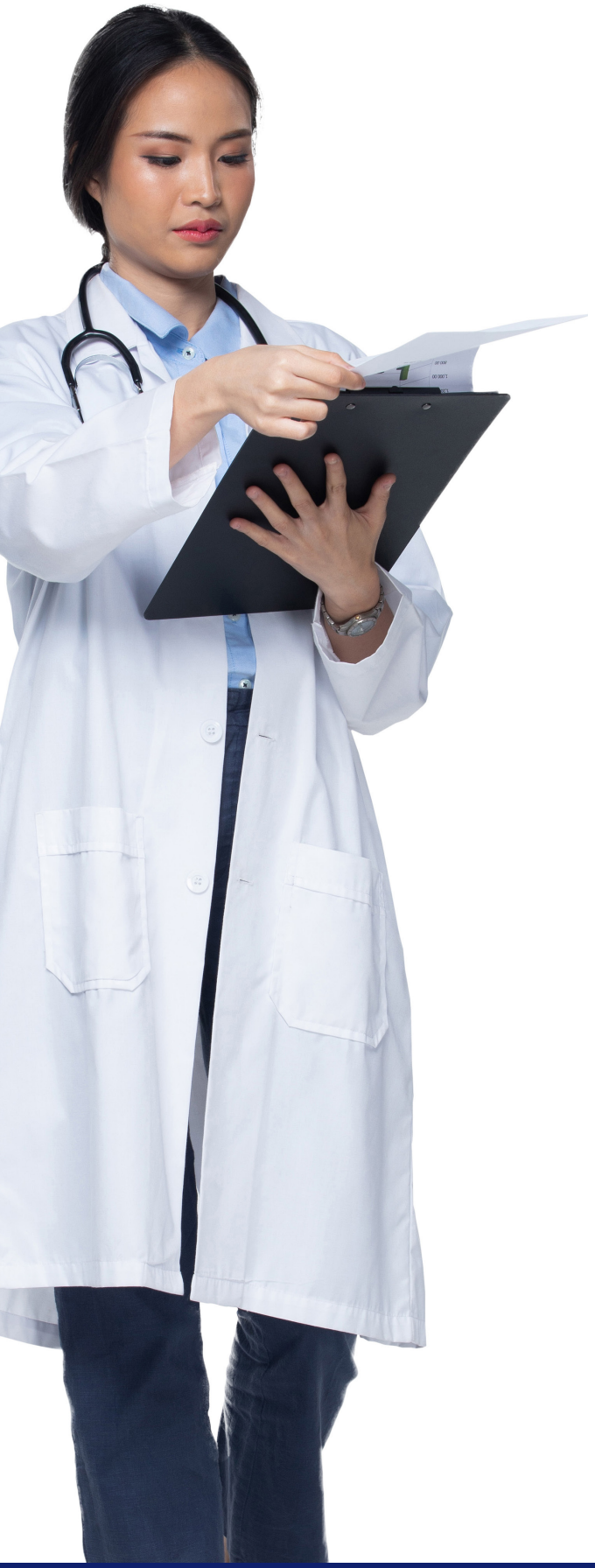
PHYSICIAN GUIDE TO

INTEGRITY IN TEXAS HEALTH & HUMAN SERVICES

Rev. 04/25



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INTRODUCTION

The State of Texas spends roughly $50 billion each year on health and human services. That is more than the entire gross domestic product of 100 nations across the globe.

And who are the Texans who rely on those programs? On average, more than four million individuals are enrolled in Texas Medicaid and the Children's Health Insurance Program. Medicaid covers approximately half of all births and nursing home residents in our state.

The Texas Health and Human Services Office of Inspector General (OIG) is statutorily charged with ensuring taxpayer dollars for health and human services are used for their intended purpose and that program participants receive the services they need.

Ultimately, the integrity of Medicaid and other health and human services programs relies on robust participation from every segment of the health care industry. Managed care organizations, contractors, program clients, hospitals, medical practices and individual providers all play a critical role in protecting Texas' taxpayers and Medicaid clients.

Without integrity, such programs would quickly lose the trust of lawmakers and the public. Pervasive fraud, waste and abuse result in increased regulation and can even endanger the existence of programs. Ultimately, this hurts the very Texans who rely on these programs for their health and well-being.

For individual physicians and health care providers, violations can be professionally and personally devastating. Improper payments must be repaid to the State, potentially impacting you and your practice financially. Additionally, serious violations can result in exclusion from the program or even criminal charges with the potential for serious jail time. In the end, fraud, waste and abuse violate your sacred oath to do no harm.

At the OIG, we know the vast majority of physicians and health care providers uphold the highest ethical standards and work diligently to comply with the many laws and regulations governing Medicaid and the health care industry, as a whole. This publication is intended as a quick reference to help new physicians understand the role they play in program integrity and how they may interact with the OIG throughout their career in medicine.

MEDICAID AND CHIP

Medicaid and CHIP are the two Texas health and human services programs you are most likely to interact with as physician. There may be other programs you encounter as a physician, but in most cases the OIG's approach to program integrity is consistent regardless of the program. More information is available the Texas Health and Human Services "Texas Medicaid and CHIP Reference Guide."

MEDICAID

Medicaid provides health care and long-term services and supports (LTSS) to low-income families and their children, pregnant women, former foster care youth, individuals with disabilities and people age 65 and older.

THE CHILDREN'S HEALTH INSURANCE PLAN

CHIP provides health care to children who are not eligible for Medicaid based on their family income. Texans who apply for benefits and do not qualify for Medicaid are automatically tested for CHIP eligibility.

PROVIDER ENROLLMENT

All providers that want to participate in state health care programs must enroll in Texas Medicaid. This enrollment requirement applies to providers who participate in:

- Traditional fee-for-service Medicaid.
- Medicaid managed care.
- Long-term care services.
- Pharmacy services.
- Ordering- and referring-only providers.

Additional information is available on the Medicaid and CHIP Enrollment and Revalidation webpage.

DEFINING FRAUD, WASTE AND ABUSE

FRAUD

Any act that constitutes fraud under federal or state law, including any intentional dishonesty or misrepresentation made by a person who knew the deception could cause unapproved benefit for themselves or another person. An example of provider fraud is upcoding, when a provider intentionally bills for a higher level of service than the one that was actually performed.

WASTE

Any practice a sensible person would consider careless or would cause excessive use of resources. An example of waste would be when a physician (unaware of the generic alternative) consistently prescribes a high-priced medication when a less expensive generic drug is available in the formulary.

ABUSE

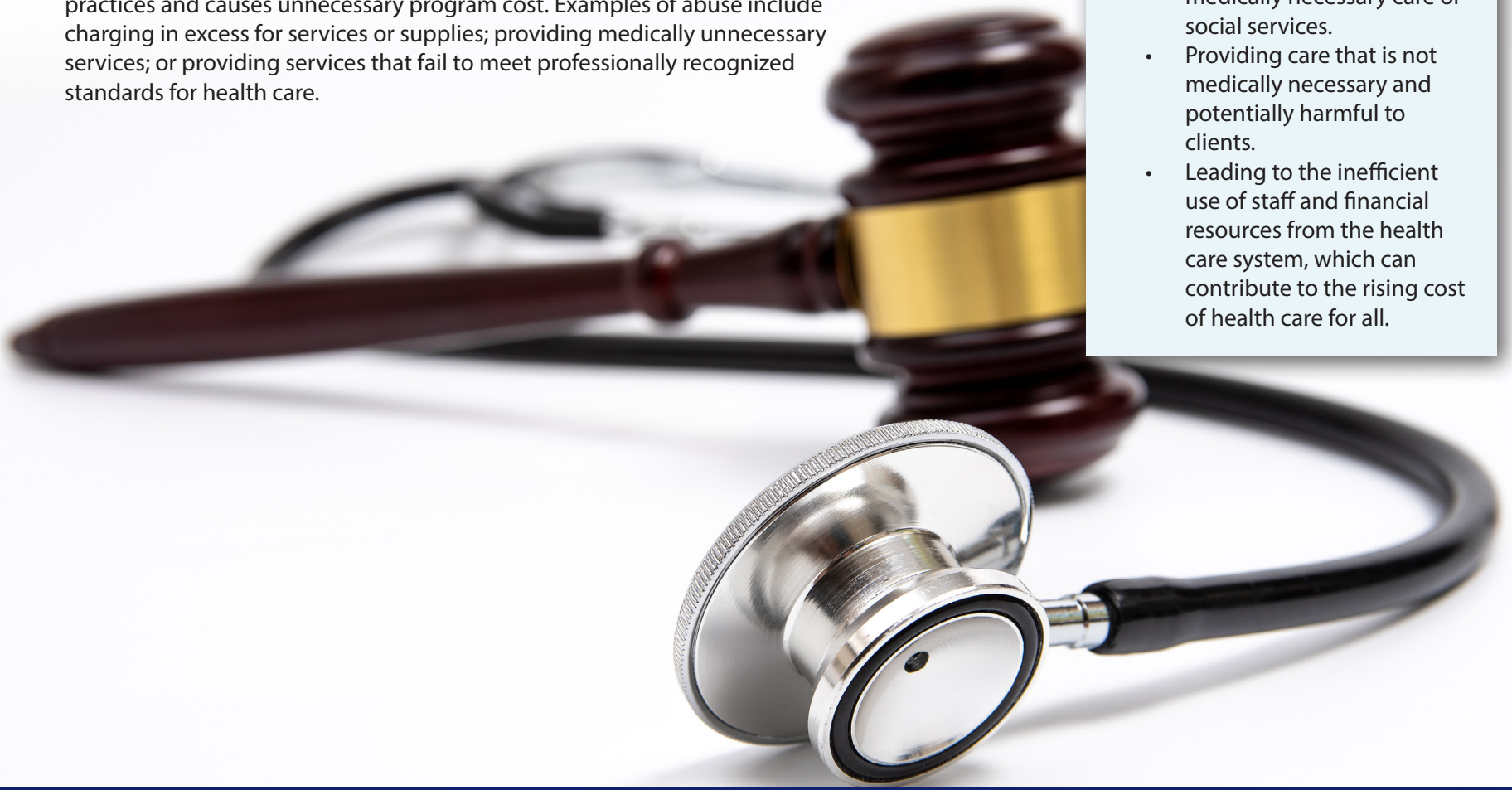
Any practice that is inconsistent with proper fiscal, business or medical practices and causes unnecessary program cost. Examples of abuse include charging in excess for services or supplies; providing medically unnecessary services; or providing services that fail to meet professionally recognized standards for health care.

THE IMPACT

Fraud, waste and abuse are a costly drain on state resources. The OIG recovers approximately half a billion dollars each year that would otherwise be lost. Thanks to this work and extensive collaboration with stakeholders, those resources can be redeployed to help Texans as intended when they were appropriated.

Fraud, waste and abuse in health and human services can also have a dramatic impact on the health and well-being of Texans by:

- Preventing or delaying medically necessary care or social services.
- Providing care that is not medically necessary and potentially harmful to clients.
- Leading to the inefficient use of staff and financial resources from the health care system, which can contribute to the rising cost of health care for all.



THE OFFICE OF INSPECTOR GENERAL

To strengthen Health and Human Services (HHS) capacity to combat fraud, waste and abuse in publicly funded state-run HHS programs, the 78th Texas Legislature created the OIG, which officially began operations in 2004. Today, the OIG is comprised of approximately 600 full-time positions at more than 30 offices across the state.

MISSION

To prevent, detect, audit, inspect, review and investigate fraud, waste and abuse in the provision and delivery of all state health and human services, and enforce state law related to the provision of those services.

AUTHORITY

Authority for the OIG's mission is found in Texas Government Code Section 544.0103.

Texas Administrative Code Chapter 371 also governs the office's actions via administrative rules that are established by the agency itself. The rules must go through a strict process that includes public comment prior to enactment, ensuring fairness and transparency. The Texas Administrative Code is overseen by the Texas Secretary of State.

OUR VALUES

The OIG upholds the highest standards of integrity as it carries out its mission. In your interactions with the office, you will see a culture that embraces a common set of core values.

- Accountability: We serve the citizens of Texas and take responsibility for our decisions and actions.
- Integrity: We demonstrate honesty and credibility.
- Collaboration: We work collectively to multiply our contribution and create shared goals leading to greater success.
- Excellence: We strive to be and do our best.

OTHER PUBLIC-FACING ROLES

In addition to working with health care providers, the OIG is also active in numerous other facets of the health and human services system. The OIG:

- Audits HHS programs and contractors to ensure compliance.
- Conducts abuse investigations at state hospitals and living centers.
- Investigates allegations of wrongdoing by program clients.

Visit ReportTexasFraud.com to learn more about the OIG.

PROVIDER REQUIREMENTS, RESPONSIBILITIES AND RESOURCES

To participate in Medicaid, providers must adhere to a variety of requirements set forth in federal and state statutes and administrative rules. It is the provider's responsibility to stay abreast of changes to these requirements. Without specifically restating those requirements, the information below provides a reference guide for providers to explore requirements and their sources in more detail.

ENROLLMENT

As previously noted in the introduction to Medicaid, providers must first be enrolled in Medicaid before they can bill Medicaid. Additional information regarding how to enroll in Medicaid can be found on the Texas Medicaid & Healthcare Partnership website.

TEXAS MEDICAID PROVIDER PROCEDURES MANUAL

The Texas Medicaid Provider Procedures Manual (TMPPM) is a comprehensive guide for Texas Medicaid providers. It contains information about Texas Medicaid fee-for-service benefits, policies and procedures including medical, dental and children's services benefits. It is updated monthly.

RECORDS REQUIREMENTS

In addition to record and document requirements set forth by the TMPPM, Texas Medical Board rule 165.1 outlines the records that should be included with each patient encounter. Patient records should be accurate and show a clear narrative that ensures continuity of care for the patient and supports billing. The basics include but are not limited to:

- All patient records for the day of service.
- Patient complaints and symptoms.
- Lab results.
- Treatment plan and progress notes, including prescriptions.

CODING AND BILLING

Physicians must follow the latest coding and billing guidelines specified in the online manuals from your MCOs, the TMPPM, and CMS National Correct Coding Initiative edits.

THE EXCLUSIONS LIST

To protect the health and welfare of people receiving Medicaid, certain people or businesses are barred from participating in the program. Medicaid providers are responsible for making sure they don't employ excluded individuals, whether as health care practitioners, assistants or clerical staff. Providers should check the state and federal OIG exclusions lists monthly and before each new hire.

PRESCRIPTIONS

The Texas Prescription Monitoring Program (PMP) and the Medicaid Lock-In Program are resources for medical professionals to identify patients who may need help with substance-use issues.

The Texas State Board of Pharmacy requires prescribers check a patient's PMP history before prescribing controlled substances such as opioids, benzodiazepines and barbiturates. The Texas Medical Board notes exceptions for patients with cancer or in hospice care. The patient prescription histories collected and monitored by the PMP can identify patients receiving multiple prescriptions from multiple doctors, pointing to evidence of potential doctor-shopping or a misuse of prescription drugs.

SELF-DISCLOSURE OF ERRORS

Section 1128J(d)(2) of the Affordable Care Act and 1 TAC Chapter 371.1655 require providers who identify that they have received undue payments from Medicaid to report and return the overpayments within 60 days. Failure to do so could be considered an independent violation and subject to sanctions.

To assist providers with the self-disclosure process, the OIG has published a quick guide and a more extensive "Self-Disclosure Protocol" on the resources section of the OIG website.

Providers and managed care organizations may use the OIG Fraud Hotline or website at any time to report any compliance or overpayment matters relating to themselves. The OIG considers self-reporting as a potential mitigating factor that may warrant less severe or restrictive administrative action or sanction.

MANAGED CARE ORGANIZATION CONTRACT REQUIREMENTS

Providers must be enrolled in Texas Medicaid before they can be enrolled by an MCO. Individual MCOs have their own guidelines for contracting providers, so be sure to consult your contract for additional requirements that may be set forth by an MCO.

FEDERAL REQUIREMENTS

The U.S. Department of Health and Human Services Office of Inspector General provides compliance information on federal regulations for new providers on their website.

THE CPT® ASSISTANT

Physicians can consult the CPT® Assistant for additional guidance on coding or patient record requirements. The Centers for Medicare & Medicaid Services offers detailed guidelines in its Evaluation and Management Services Guide.

THE OIG WEBSITE

These resources and more can be found on the Provider Resources section of the OIG website.

PROVIDER INTERACTIONS WITH THE OIG

THE OIG TOOL BOX

The OIG protects the integrity of HHS programs and systems by using a variety of tools, which each follow nationally recognized standards. These include:

Audits

Audits examine the performance of contractors, providers and HHS programs to reduce fraud, waste and abuse throughout the HHS system. Audits often focus on the accuracy of medical provider payments and provide independent assessments of HHS programs and operations. Each year the OIG publishes an audit and inspections plan to its website, detailing the office's focus for the upcoming year. All OIG audits follow U.S. Government Accountability Office Government Auditing Standards, commonly referred to as the "Yellow Book."

Inspections

Inspections focus on systemic issues and risk assessment and help detect wrongdoing early in the program lifecycle. OIG inspections are conducted in accordance with the Quality Standards for Inspection and Evaluation, or "Blue Book," published by the Council of the Inspectors General on Integrity and Efficiency.

Investigations

Investigations focus on alleged intentional abusive, wasteful or fraudulent practices. OIG investigators examine provider payments, disability fraud and electronic benefits trafficking.

Reviews

Reviews uncover problems in documentation, billing and payments. The office reviews a variety of claims and medical records, including acute care utilization, hospital utilization, and nursing facility utilization. OIG reviews follow the U.S. Government Accountability Office's Standards for Internal Control in the Federal Government, known as the "Green Book."

IDENTIFYING PROVIDERS FOR A CLOSER LOOK

The subjects of OIG audits, inspections, investigations and reviews are selected based on either referral or the OIG's own Medicaid Fraud and Abuse Detection System.

Referrals

Referrals are made to the OIG Fraud Hotline or online reporting system by a variety of sources. These include MCOs, other government agencies, members of the public or other providers.

Medicaid Fraud and Abuse Detection System

In recent years, the OIG's work has been transformed by the use of data analytics as part of the statutorily required Medicaid Fraud, Waste and Abuse Detection System (MFADS). These internal, data-driven initiatives examine Medicaid claims and flag unusual billing patterns and providers who appear as outliers compared to their peers. OIG investigators then take a closer look to determine if outlier status is due to fraud, waste, abuse or some other reason. Additional information on OIG data initiatives is included in a later section of this resource.

THE PROCESS

Investigations and reviews are the most common way physicians interact with the OIG and will be the focus of this section, but providers can expect a very similar process regardless of the type of interaction or how it was initiated.

Surveillance Utilization Reviews

The Centers for Medicare & Medicaid Services (CMS) requires each state to perform surveillance utilization reviews. The OIG Surveillance Utilization Review (SUR) Unit conducts claim and medical record reviews to validate that the services billed and paid conform to Texas Medicaid and MCO policies. In these billing reviews, the OIG's team of nurses review medical records to ensure the documentation accurately reflects:

- The level of service billed.
- The service or supply was actually provided.
- Medical necessity.
- Correct coding guidelines.
- Policies and procedures were followed.
- No duplicate billing.
- No billing for non-covered services.

Validating Medicaid codes

Accurate medical coding prevents waste in health care delivery. Incorrect codes result in overpayments — which impact taxpayers — and underpayments, which can impact your practice.

The OIG follows coding guidelines from the Healthcare Common Procedure Coding System and Current Procedural Terminology.

To begin a coding review, the OIG analyzes statistically valid data that compares physicians and other health care professionals with their peers based on their billing patterns and payments received. This ensures providers are compared with similar providers. For example, a doctor of osteopathic medicine (DO) working in oncology would be compared with other DOs working in oncology.

An OIG nurse reviewer will examine any case where a physician or medical practice appears as an outlier among their peers and then request patient records to substantiate what was billed and paid. Requested records typically include but are not limited to:

- All documentation for the day of service.
- Patient complaints and symptoms.
- Lab results.
- Treatment plan and progress notes, including prescriptions.
- Prior authorizations.
- Referrals.

CASES IN POINT

E&M CODES

A physician agreed to pay $20,000 for allegedly billing for office consultations using E&M codes that were not supported by the clinical records, as the CPT code required a higher complexity of medical decision-making than the reviewed records indicated. The OIG review of patient files also identified billing for diagnostic tests without sufficient clinical indication to justify medical necessity for those exams.

In another instance, a practice self-disclosed errors that included upcoding some E&M services for which the supporting documentation did not strictly comply with E&M documentation guidelines in the CPT manual. The practice agreed to repay Medicaid approximately $200,000.

EEG SERVICES

The OIG settled several cases where neurologists and other clinicians billed for EEG services that require 24-hour monitoring by a clinician who can intervene in monitoring or patient care as needed. However, the providers were equipping patients with mobile EEG units and sending them home for overnight monitoring without 24-hour monitoring by a clinician. As a result, the providers received a higher reimbursement amount. The OIG worked with the providers to prevent future improper reimbursements.

A physician with Texas Medicaid's claims administrator will also review the records and the initial findings. The nurse reviewer will then notify the health care professional of the findings. A case is closed without further action if patient records support the billing and payments. If billing errors are noted in a review, follow-up actions can include education and/or payment recoupment. Physicians have two opportunities to appeal the findings.

Common mistakes

The most frequent error the OIG observes in reviews is physicians submitting billing codes that are not supported by patient records. The physician's notes should support everything billed on the date of service and demonstrate medical necessity.

For each Evaluation & Management code billed, a physician must detail the time spent with the patient and/or the level of medical decision-making involved for that date of service. Notes should include any time spent educating the patient and family, prepping for the visit, and coordinating care. The level of visit also may include history appropriate for that visit, but physicians should not clone notes from a patient's previous visits.

Including modifiers

CPT modifiers provide additional information concerning a procedure or service provided by a physician. Physicians must add the appropriate two-digit modifier if specific circumstances accompany a service or procedure. Using modifiers to add descriptive information, when necessary, can help improve the accuracy of recorded patient encounters. For example, if a physician supervises multiple nurse practitioners or physician assistants but doesn't use a modifier to show that, the claims will look like one doctor is billing for simultaneous appointments throughout the day; that behavior often invites closer examination.

When adding more than one modifier, list the payment modifier first and then those that add other information. Records must demonstrate the pertinence of any added modifiers.

Investigations

Preliminary investigations

Referrals to the OIG Provider Investigations Unit go through a preliminary investigation, which typically involves a request for records including patient records for the day of service, patient complaints and symptoms, lab results, treatment plans, prescriptions, prior authorizations, referrals for specialty care, lab referrals, procedural notes, and business records. Additional specific items may be requested, depending on the services under review.

Full-scale investigations

Cases that meet evidentiary and other statutory requirements are transferred for a full investigation, where additional records may be requested, and OIG investigators interview providers, clients and staff.

Outcomes

A case is closed without further action if patient records justify the billing and payments. If issues are found, providers may be subject to a variety of administrative enforcement actions. These include but are not limited to:

- Education to prevent future occurrences.
- Prepayment review of claims.
- Recoupment of Medicaid overpayments.
- Assessment of penalties.
- Termination or exclusion from the Medicaid program.

Providers have the right to appeal alleged errors.

Investigations involving suspected criminal Medicaid fraud are referred to the Texas Attorney General's Medicaid Fraud Control Unit (MFCU).

OTHER POTENTIAL OIG INTERACTIONS

Medicaid Lock-In Program

The OIG's Medicaid Lock-In Program restricts or locks a Medicaid client to a designated pharmacy or provider if it finds the member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive or conflicting or the member's actions indicate abuse, misuse or fraud. Providers play a key role in identifying and referring clients to the program. Candidates for new or continued lock-in may be referred by calling the OIG Fraud Hotline at 1-800-436-6184 or by using the online reporting system.

Reporting suspected fraud, waste or abuse

Collaboration is a vital part of protecting Medicaid system integrity, and everyone can play a role in preventing fraud, waste and abuse. Call the OIG Fraud Hotline at 1-800-436-6184 or use the online reporting system if you suspect wrongdoing by providers or recipients in Texas health and human services programs.

DATA ANALYTICS IN FRAUD PREVENTION

Data analytics provide a vital tool in the OIG's fraud detection and prevention efforts. Recent advances in data collection and analysis capabilities allow the OIG to recover taxpayer dollars more efficiently, offer preventative education and make proactive policy recommendations to improve future compliance. OIG staff develop complex algorithms and models to analyze the behavior and billing practices of providers, clients and managed care organizations and identify trends and patterns that might be indicative of potential fraud, waste and abuse.

Data analytics allow investigators to identify risks program-wide instead of relying on individual referrals to identify misuse by a single provider. For example, investigators can use an algorithm, developed by studying the behavior of previously flagged providers, to analyze statewide data and rapidly uncover systemic issues across Medicaid MCOs and providers.

This process can lead to an initiative focused on prevention — where the OIG educates MCOs and the provider community through letters and presentations about issues and trends — or an investigation, where the OIG addresses individual provider behavior and recovers misspent funds.

Using data analytics, OIG staff recently identified a repeated issue with emergency room injection and infusion reimbursements. The data indicated outpatient hospital facilities were billing for the administration of injections or infusions in the emergency department when those services were already covered by the ER evaluation and management reimbursement.

As a result, the OIG has settled dozens of outpatient hospital injection and infusion cases, totaling more than $30 million in overpayments. The OIG is also working to develop education and outreach to help providers and MCOs prevent similar overpayments moving forward.

In addition to the injection and infusion cases, OIG staff have employed algorithms and data analysis techniques to identify outliers and test for potential telehealth violations within the Texas Medicaid program.

The OIG also conducts data-driven investigations and reviews of individual providers that appear as statistical outliers among their peers, based on billing patterns. Outlier status is not an automatic indicator of wrongdoing, nor will every outlier be selected for a formal investigation. OIG teams evaluate additional records to determine if outlier status is due to fraud, waste or abuse, or for some other reason.

The OIG's data team creates new algorithms every year to respond to the latest threats to provider and program integrity.

CASE IN POINT

DATA ANALYTICS

The OIG entered into a settlement agreement with a pediatric medical clinic for $522,901. Claims data indicated that between February 1, 2017, through January 31, 2021, the provider billed for a Strep A-Molecular Panel on the same date or within three days of billing for a Strep A Rapid Test, without a subsequent visit, precluding the possibility of another specimen being collected for testing. The OIG identified, through data analytics, 23,500 instances in which the molecular panel was improperly billed and reimbursed. According to the Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI), these are mutually exclusive services and should not be reimbursed on the same day for the same recipient. Additionally, according to the CMS Laboratory Date of Service Policy, the date of service must be the date the specimen was collected. The OIG verified that all managed care organizations (MCOs) define the date of service in accordance with CMS policy.

TELEMEDICINE CONSIDERATIONS

The evolving nature of health care delivery due to technology necessitates physicians' ongoing attention to remain in compliance. When COVID-19 prompted the increased use of telemedicine to connect physicians with their patients, the shift in service delivery and demand presented new program integrity challenges. The OIG identified several common issues:

MULTIPLE SERVICES WITHIN A BRIEF TIME

Certain billing patterns can indicate wasteful errors or possible suspicious activity. One issue of interest is billing for multiple telemedicine or telehealth services on the same client in a short period of time, such as one month or even one day.

Examples of provider behavior indicating potentially improper billing:

- Physicians calling patients as a "follow up" within the same week as a telemedicine visit and billing an Evaluation and Management (E&M) code.
- Physicians performing telemedicine visits, then an in-person visit, with modifier 25 (separately identifiable service) for the same diagnosis.
- Physicians calling patients they had not recently seen and who had not requested an appointment to "check up" on them and billing an E&M code.

CASE IN POINT

BEHAVIORAL HEALTH AUDIT

The OIG audit examined teleservices claims paid for evaluation and management with add-on psychotherapy services. The audit revealed that the clinic billed for more time than was spent with clients for the psychotherapy services, as evidenced by the durations recorded in their medical records and telemedicine platforms. The audit identified more than $50,000 in extrapolated overpayments for the provider. Providers must ensure that claims for services billed as time-based CPT codes are based on the actual length of services provided.

IMPOSSIBLE HOURS

Using timed procedure codes, providers are flagged for billing in excess of 24 hours in one day, possibly due to some of the billed services actually being rendered by a supervised physician assistant. If this is the case, excess hours are taken into consideration. MCO-contracted physicians billing for impossible hours across several MCOs on the same date of service also attract attention, meaning a provider is billing for two hours in one day with one MCO but is billing for 30 hours that day across several MCOs.

TELEPHONE-ONLY SERVICES

Telemedicine provided via telephone-only introduces a new facet for patient evaluation and management. Billing more than one E&M code a day, with modifier 25, for a patient would lead to improper reimbursement. The Texas Medical Board and Health and Human Services Commission issued guidance regarding billing for telephone calls. E&M services cannot be billed if the physician determines an in-person or video telemedicine visit is required within 24 hours or at the next available appointment time, as the services rendered via telephone will be considered part of the office or video visit. If a call follows an office visit within seven days for the same diagnosis, the telephone call is considered part of the previous visit and cannot be billed separately.

PATIENT RECORD REQUIREMENTS

Telemedicine services require the same record-keeping and note-taking standards as for services performed in person, according to the Texas Medical Board. Given the temporary telemedicine flexibilities that allow physicians to establish patient relationships and prescribe controlled substances via telemedicine — including audio-only visits — and be paid at the same rate as in-office visits, physicians must continue to demonstrate that services were provided and met the standard of care. Patient consent for treatment via virtual visit is also required.

OTHER RESOURCES

Additional resources are available on the U.S. Department of Health and Human Services Office of Inspector General's telehealth webpage.

(800) 436-6184

www.ReportTexasFraud.com

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