Annual Report

Fiscal Year 2019

Department of the Inspector General

Office of the Medicaid Inspector General

Message from the Medicaid Inspector General

I am pleased to present the Medicaid Inspector General's annual report for State Fiscal Year 2019 to Governor Asa Hutchinson, Attorney General Leslie Rutledge, the Legislature, and the citizens of Arkansas.

The mission of the Office of the Medicaid Inspector General (OMIG) is to identify and prevent fraud, waste, and abuse in the Arkansas Medicaid Program. To fulfill the mission, OMIG utilizes traditional program integrity methods of provider auditing and education as well as development and implementation of new analytic tools to enhance these efforts. OMIG's tested formulas and audit staff have continued to excel.

For State Fiscal Year 2019, OMIG identified $3,956,159.19 for recovery. Since its formation in 2013, OMIG has identified over $20 million dollars in improperly paid claims, and OMIG expects that number to grow in the future.

Recoveries only account for a small portion of the fiscal impact OMIG has made on the Medicaid Program. For the past year alone, OMIG's work led to realized cost savings of over $41 million dollars to the Medicaid program. The majority of the cost avoidance is attributed to the policy revisions related to Group Psychotherapy billing code 90853, implementation of the new outpatient Behavioral Health Program, and the Provider-Led Shared Savings Entities (PASSE) model. Over the past three fiscal years, the Group Psychotherapy changes have resulted in overall cost savings of over $77 million. Additional areas of identified cost avoidance this year include Arkansas Works recipient eligibility review, provider billing for allergy immunotherapy, vision provider billing for duplicate refractions, and the reimbursement rate for non-sterile gloves.

The recent move toward managed care for dental services and recipients receiving behavioral health and developmental disability services has brought changes to OMIG's method of review. OMIG has worked closely with the provider organizations to ensure program integrity compliance and that their special investigative units are identifying and reporting fraud, waste, and abuse to OMIG.

OMIG's identification of program integrity vulnerabilities and our recommendations to the Department of Human Services for changes in policies, programs, and fee structures has directly impacted Arkansas Medicaid and helped ensure a fiscally responsible program. Looking ahead to 2020, OMIG will continue to foster positive relationships with Medicaid providers and to work closely with local, state, and federal entities to protect and safeguard that all state and federal dollars are being spent appropriately to provide necessary treatment and services to Arkansas Medicaid recipients.

Respectfully,

Elizabeth Thomas Smith

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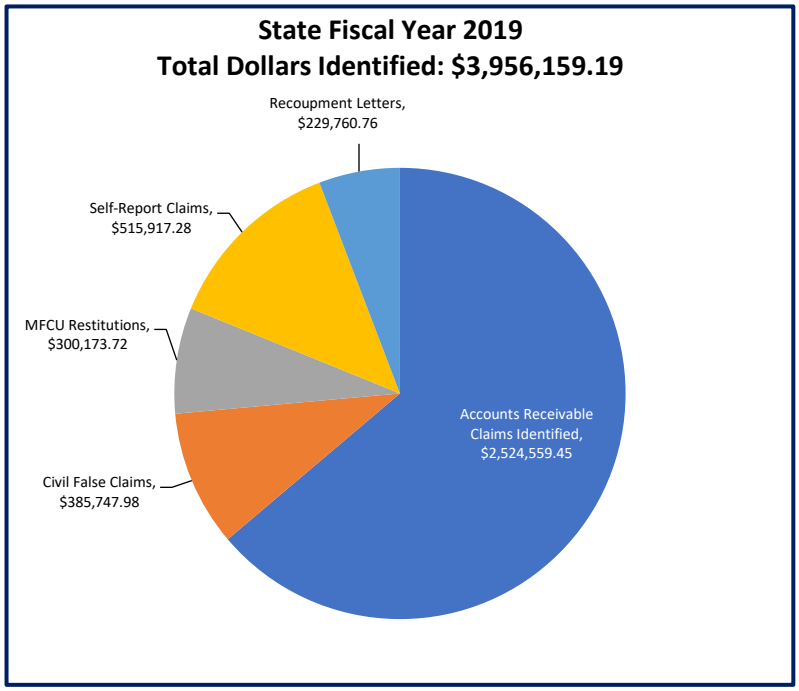
OMIG Recoveries and Recoupments

OMIG Identified Dollars for Recovery

The total amount of Medicaid funds identified for recovery in State Fiscal Year 2019 by OMIG activities is $3,956,159.19. As noted in the chart, OMIG uses various methods to identify improperly paid Medicaid dollars, including: restitution from criminal fraud and civil false claim referrals to the Medicaid Fraud Control Unit, audits and recoupment letters identified as accounts receivable claims, provider self-reports, and recoupment letters based on data analysis. OMIG continues the Provider Awareness Letter initiative and provider educational seminars to impress upon providers the importance of self-reporting overpayments. These efforts continue to show results.



OMIG Collections

In State Fiscal Year 2019, $2,618,042.39 was collected as a result of OMIG activities from this and prior state fiscal years. Recoupment and adjustment of claims occur through the Medicaid Management Information System (MMIS) and often spans several months or even state fiscal years. Therefore, identified claims and recovery amounts do not always occur in the same year. Most dollars recovered were a result of collections through DHS claims adjustments.

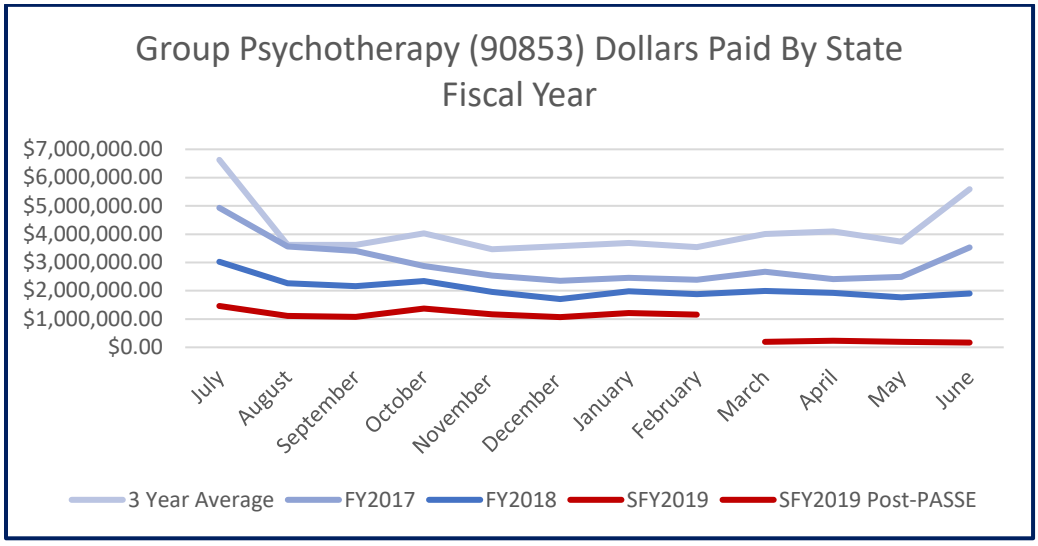
SFY 19 OMIG Dollars Recovered

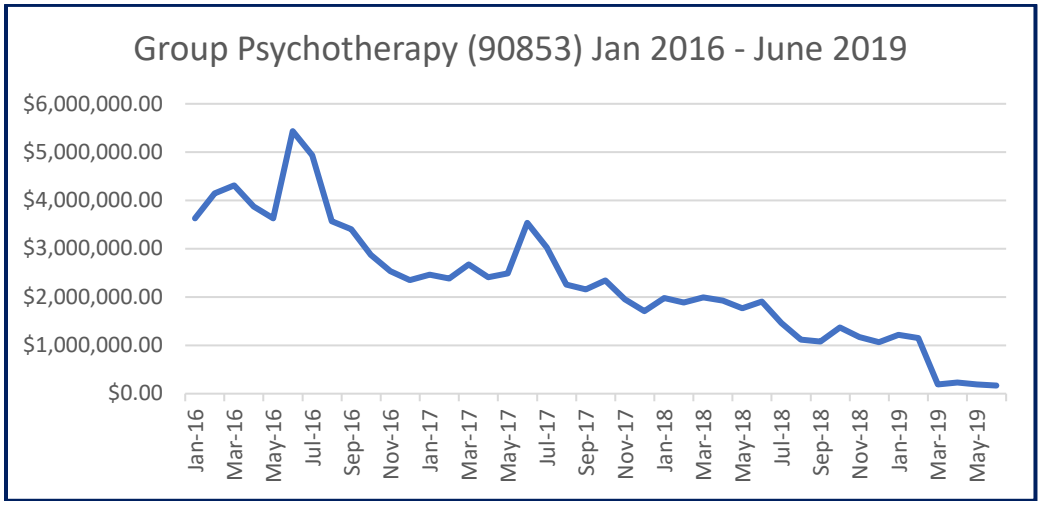
Accounts Receivable Claims	$1,713,458.56
Self-Report Collections	$606,448.28
Crossover Claims Reversals	$222,530.04
Restitution and False Claims	$75,605.51
TOTAL	**$2,618,042.39**

Cost Avoidance

Group Psychotherapy

The 90853 Group Psychotherapy Initiative has been one of the most successful initiatives since the creation of OMIG. The previous policy for 90853 Group Psychotherapy billing created vulnerability in the Medicaid program for fraud, waste, and abuse. OMIG's recommendation to reform the 90853 code has resulted in savings of an estimated $77.8 million since the initiative began in Fiscal Year 2017, with an estimated $39.1 million in Fiscal Year 2019 with the implementation of significant reforms to the behavioral health program. The Outpatient Behavioral Health program began in July 2018 and then the Provider-Led Shared Savings Entities assuming full risk of much of the behavioral health population in March 2019. OMIG continues to audit and investigate behavioral health issues in collaboration with the PASSEs Special Investigations Units while implementing necessary interventions to combat fraud, waste, and abuse for this vulnerable population of recipients.

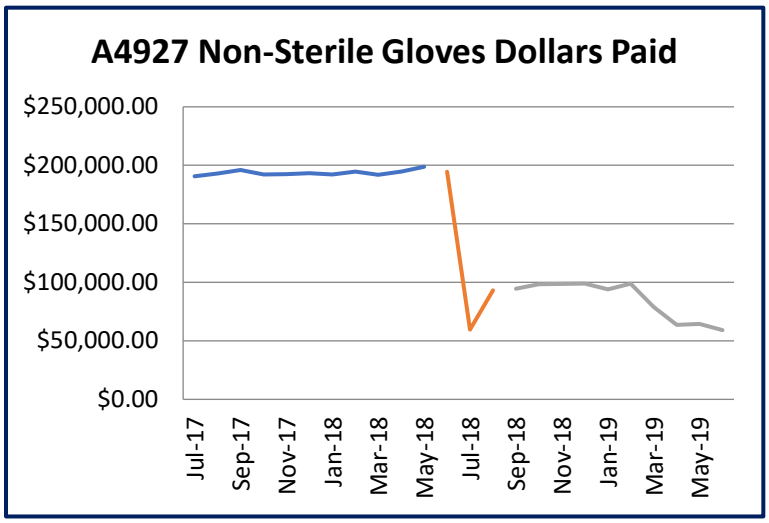




Cost Avoidance

Non-Sterile Gloves

In June of 2018, OMIG sent 166 courtesy letters to durable medical equipment/prosthetics providers to clarify the unit definition and reimbursement rate in the Arkansas Medicaid Provider Manual for non-sterile gloves (procedure code A4927). OMIG identified a discrepancy between the Medicaid Provider Manual and the Medicaid Fee Schedule for reimbursement of non-sterile gloves. OMIG conducted a thorough analysis of paid claims and consulted with DME and Home Health providers. OMIG then recommended DHS review and revise the Fee Schedule to correct the discrepancies as well as to save Medicaid funds.



As a result, the review resulted in a change in the reimbursement amount for procedure code A4927 to $5.22 per 100 gloves effective August 1, 2018.

Based on billing volume for the previous fiscal year, this fee schedule change has resulted in an estimated $1.35M in cost avoidance for A4927. This equates to approximately a 57% reduction in cost for this item for the Medicaid program.

Arkansas Works Recipient Eligibility Review

In State Fiscal Year 2018, OMIG began an initiative to determine whether Arkansas Works Premium payments were being made on behalf of incarcerated persons. Data analysis matched the inmate data with enrollment data and confirmed that Arkansas Works was indeed paying premiums on behalf of incarcerated recipients. In September 2017, Inspector General Smith immediately reported this finding to DHS in an effort to return improper payments made in October of 2017, and to avoid future improper premium payments.

OMIG continued review the matched recipients to determine whether other premiums were improper. In February 2018, OMIG notified DHS a total of $2,474,238.15 had been paid in Arkansas Works premiums during 2017 for recipients incarcerated in the ADC. OMIG requested DHS recover these payments and requested a corrective action plan to prevent future improper payments.

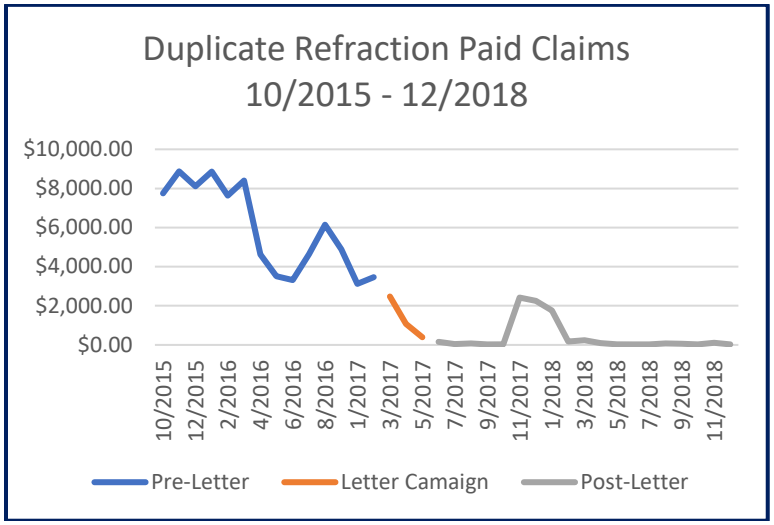
OMIG continues to work with DHS and ADC to create a functional streamlined process to identify the incarcerated recipients to avoid improper payments going forward. As a result of

Cost Avoidance

OMIG's identification of this issue and ongoing oversight, DHS has implemented a corrective action plan to prevent these payments from occurring in the future and has recovered $612,460.61 in improper payments for inmates made in State Fiscal Year 2019.

Duplicate Refraction

Beginning in State Fiscal Year 2017, OMIG identified multiple instances in which vision providers billed for duplicate refraction exam claims by submitting a refraction procedure on the same date of service as a comprehensive ophthalmological exam, which includes refraction. This review revealed that the duplicate claims resulted from an incorrect interpretation of Medicaid rules or problems with electronic billing software. In 2017 OMIG notified Providers of recoupment of improper payments and educated the Providers on proper billing procedures.



In State Fiscal Year 2019, OMIG conducted a lookback review of refraction claims to determine compliance with previous fiscal years' education efforts. This review showed a significant decrease in noncompliance; only 24 providers billed these procedures improperly compared to 65 in State Fiscal Year 2017. Compared to the initial results in 2017, the State Fiscal Year 2019 reviews resulted in a 91.2% decrease in identified improper payments for duplicate refraction billing which equates to an approximate $76K cost avoidance based on this initiative. OMIG will continue to review claims for these procedures for compliance in State Fiscal Year 2020.

Adult Allergy Immunotherapy over Age 21

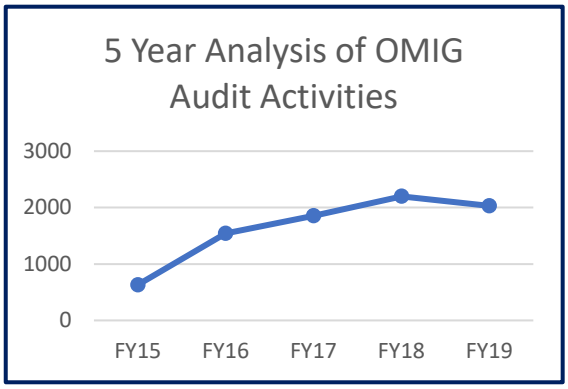
The Physician-Arkansas Medicaid Provider Manual allows payment for allergy immunotherapy services for eligible children under the Child Health Services Code. These services are not reimbursable for beneficiaries age 21 and older.

Cost Avoidance

Through data analytics, OMIG identified improperly paid claims for Immunotherapy CPT Codes 95115-95199 for recipients aged 21 and older from January 1, 2015 through December 31, 2017. In February 2018, OMIG sent a total of 67 recoupment letters notifying providers of the improper payments and educating on proper billing procedures. OMIG recovered a total of $26,340.56 in improperly paid claims.

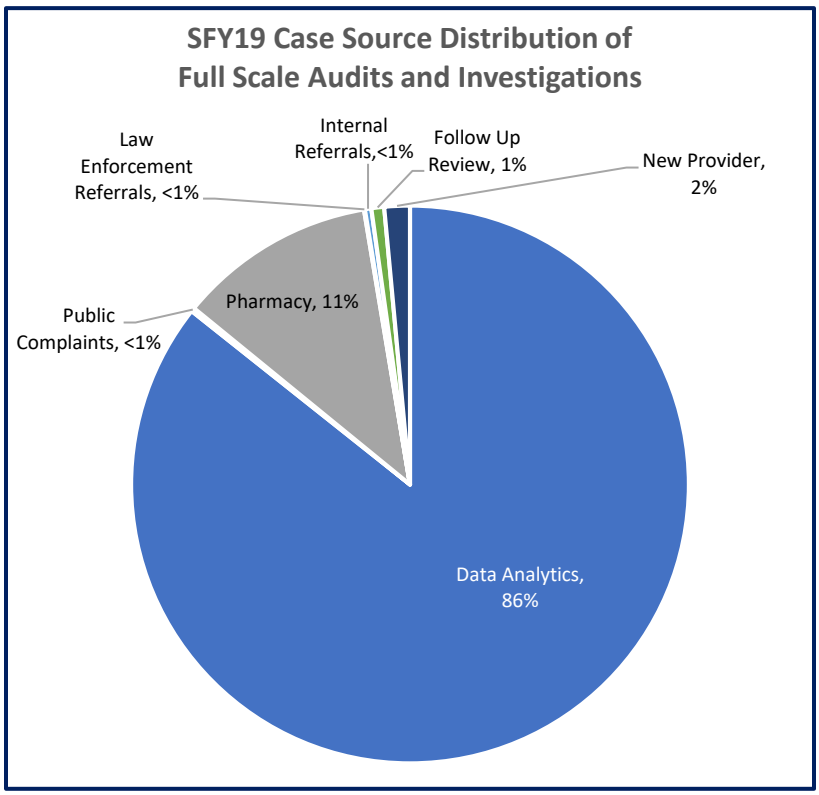
In February 2019, OMIG conducted a lookback review for compliance with the previous year's education for allergy immunotherapy services. This review showed a 93.1% decrease in noncompliance - only $1,812.36 in improperly paid claims were identified. Comparing the State Fiscal Year 2019 to the average spend prior to OMIG's educational campaign, there is an estimated $4,287.06 cost avoidance per state fiscal year for this initiative, and OMIG continues to recover these improper payments and educate providers.

OMIG Audit Activities



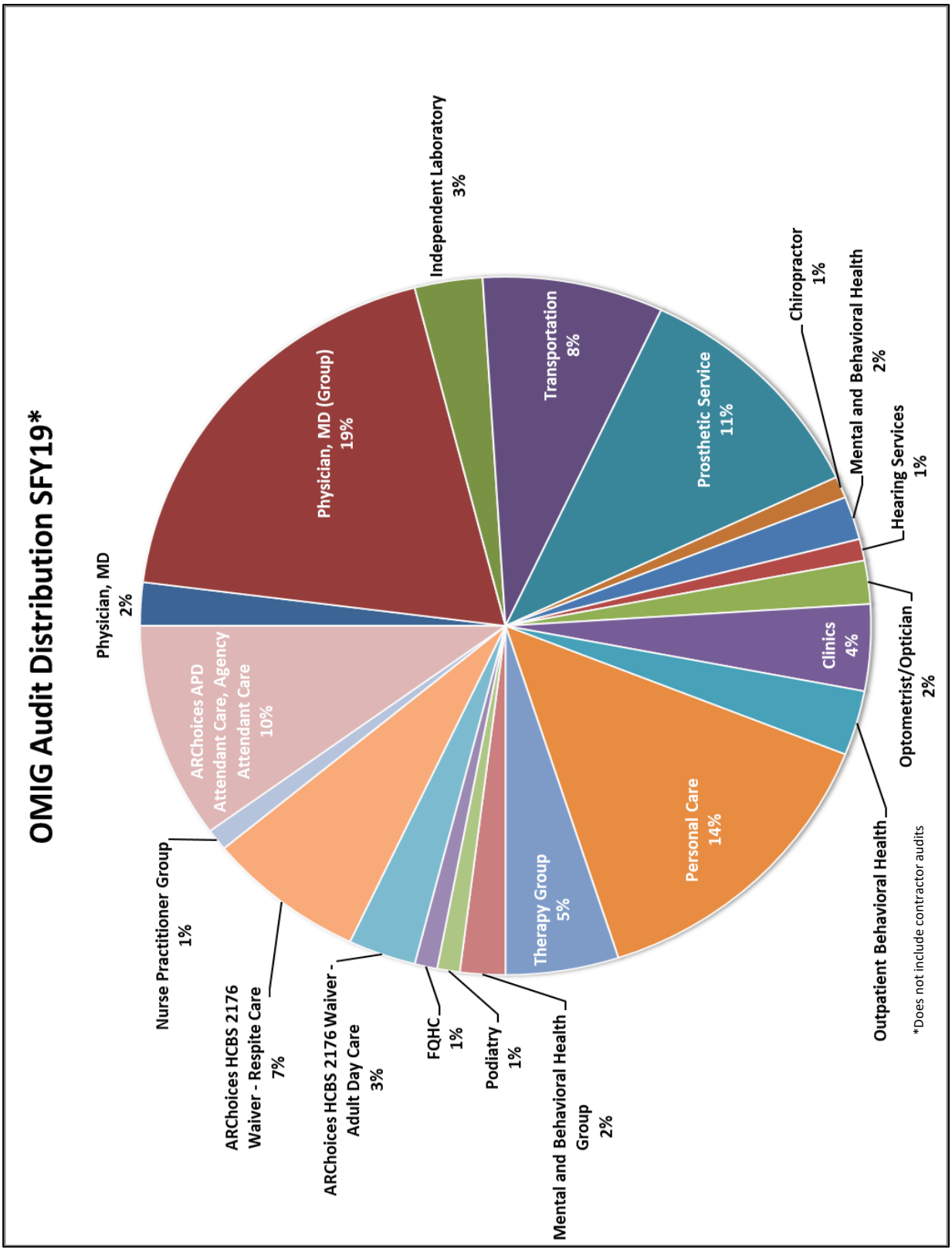
OMIG uses a multi-faceted audit approach with professionally trained auditors, coders, and medical professionals to review medical records for fiscal integrity. Providers are also directed by OMIG to perform self-audits which are then reviewed by OMIG for compliance. Reports of potential violations of the Arkansas or Federal False Claims Act (FCA) are investigated through a compliance review process.

OMIG continues to expand data analysis capabilities to detect potential practices of fraud, waste or abuse, and initiates data-driven recovery letters seeking return of funds. Cases opened from data analysis account for 86% of all cases, compared to 51% of cases in the previous fiscal year. In State Fiscal Year 2019, the number of onsite audits, desk audits, provider self-audits, FCA Compliance Reviews, and recoupment letters totaled 2,094 separate events or cases, broken down in the following charts. OMIG places special emphasis on reviewing high-risk and new providers for compliance, as illustrated in the distribution of provider types reviewed in State Fiscal Year 2019 as seen on the next page.



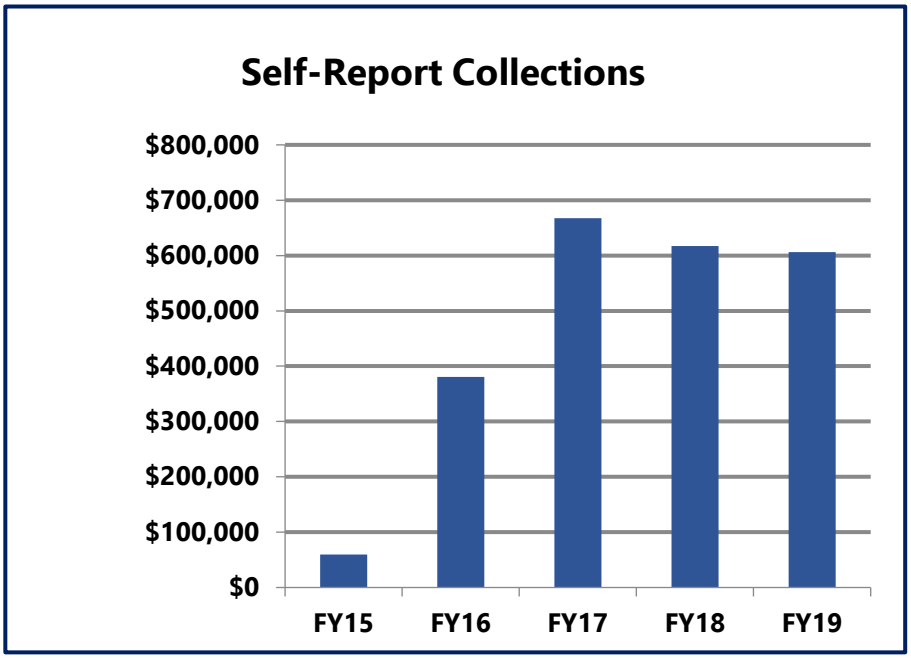
Summary of Audit Activities

Onsite Audits	22
Desk Audits	78
Provider Self Audits	70
False Claims Act Reviews	135
Contractor Audits	217
Recoupment Letters	1,572
TOTAL	**2,094**


OMIG Audit Distribution SFY19*
Physician, MD 2%
Physician, MD (Group) 19%
Independent Laboratory 3%
Transportation 8%
Prosthetic Service 11%
Chiropractor 1%
Mental and Behavioral Health 2%
Hearing Services 1%
Optometrist/Optician 2%
Clinics 4%
Outpatient Behavioral Health
Personal Care 14%
Therapy Group 5%
Mental and Behavioral Health Group 2%
Podiatry 1%
FQHC 1%
ARChoices HCBS 2176 Waiver - Adult Day Care 3%
ARChoices HCBS 2176 Waiver - Respite Care 7%
Nurse Practitioner Group 1%
ARChoices APD Attendant Care, Agency Attendant Care 10%
*Does not include contractor audits

Medicaid Provider Self-Reports

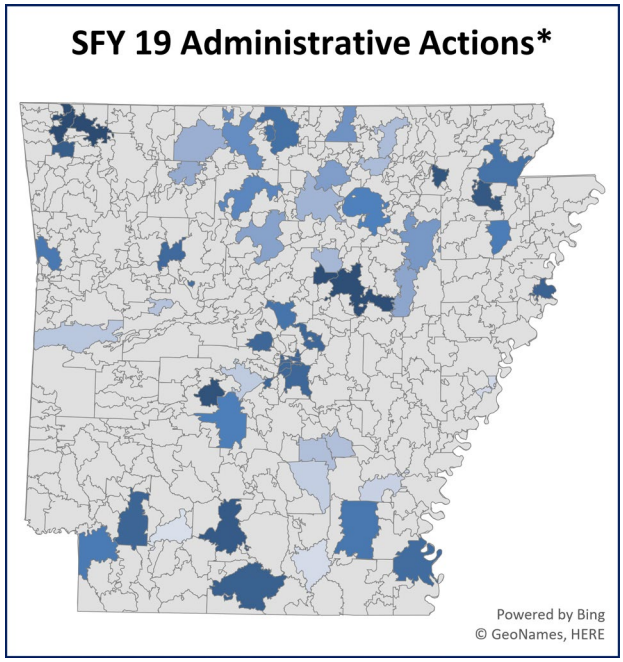
In State Fiscal Year 2019, a total of $515,917.28 was reported by Medicaid Providers as improper payments received in error from the Arkansas Medicaid program, and a total of $606,448.28 was collected for this and other previous fiscal years. Of the amount identified, $45,511.46 was reported in response to letters sent to providers pursuant to the Provider Awareness Letters (PALs) initiative, while the remainder was comprised of independent reports from providers. OMIG's self-report procedure enhances elimination of fraud, waste, and abuse, while decreasing provider burden by offering Medicaid providers a mechanism to reduce their legal and financial exposure through compliance. Providers who are self-reporting must submit a Corrective Action Plan (CAP) including appropriate measures to prevent recurrence of identified issues.



Administrative Actions

Suspensions and Exclusions

OMIG pursues administrative actions against individuals and entities engaging in fraud, abuse, and improper billing practices. Administrative actions include suspension from payment or exclusion from participation in the Medicaid program. When OMIG refers criminal actions to MFCU, the law requires that the provider be suspended under almost all circumstances. OMIG will then exclude or reinstate the provider, depending on the outcome of the criminal matter. OMIG also pursues suspension or exclusion as a sanction outside of criminal matters in cases when a provider continually abuses the program. Regardless of the circumstances of suspension or exclusion, each provider is afforded legal due process to appeal OMIG's decision in a hearing before an Administrative Law Judge. During this Fiscal Year, OMIG suspended 70 medical providers and excluded 32. The map below depicts the suspensions and exclusions by county in which the Medicaid Provider's home office is located. OMIG excluded Medicaid Providers in 46 counties for State Fiscal Year 2019.



*Map does not include 3 out-of-state administrative actions for providers in Hollande, MS, Poplar Bluff, MO, and New Braunfels, TX.

Provider suspensions	70
Provider exclusions	32
SFY 2019 Total	**102**

Fraud Referrals

Provider Fraud

OMIG has increased the use of and reliance on data analytics to identify fraud consistent with national and federal program integrity trends which produces more effective and efficient investigations. OMIG also receives leads for investigation from audits, public complaints received through the OMIG fraud hotline, agency referrals, and law enforcement referrals.

In State Fiscal Year 2019, 101 cases were opened for fraud investigation. OMIG referred 76 of these cases to MFCU for fraud with 53 of the providers being suspended for a credible allegation of fraud. The majority of these cases relate to a Behavioral Health provider organization with multiple locations throughout the state. Investigations relating to this group of providers are still ongoing, and the group continues to be suspended from receiving payment from the Arkansas Medicaid Program. The remaining criminal referrals include, among others, dentists who billed for services that were not provided, personal caregivers who billed for services that were not provided to disabled clients, and fraudulent pharmacy billing.

Recipient Fraud

In State Fiscal Year 2019, OMIG referred 32 cases of suspected recipient fraud to DHS for determination of recipient eligibility. When Beneficiary eligibility fraud is identified, those cases are then referred to law enforcement for prosecution. Cases involving collusion between Medicaid recipients and Medicaid providers are investigated by MFCU. This year, OMIG identified and referred 2 cases of recipient fraud in connection with Medicaid provider fraud to MFCU. Both collusion cases encompassed a recipient and a personal caregiver.

Program and Policy Review

Electronic Visit Verification

The 21st Century Cares Act required State Medicaid Agencies to implement electronic visit verification (EVV) for all PCS and home health services requiring provider in-home visits by January 1, 2020. OMIG has worked closely with the Department of Human Services in oversight of the procurement process and in finalizing appropriate contract deliverables. A robust EVV program can be used to regulate and prevent improper billing and Medicaid fraud to better serve Medicaid recipients. OMIG anticipates EVV will strengthen existing Program Integrity measures in the home and community-based services. This additional data will further identify fraud, waste, and abuse in these programs and will help to protect some of the most vulnerable Medicaid recipients who are dependent upon these valuable services.

Dental Managed Care Oversight and Collaboration

Delta Dental of Arkansas and Managed Care of North America Dental (collectively, MCOs) serve as the dental benefits managers for the Arkansas Medicaid/CHIP program, providing dental services to Medicaid recipients. OMIG acts in an oversight role for program integrity to bolster transparency and accountability by imposing and clarifying requirements meant to reduce fraud, waste, and abuse. OMIG continues to monitor quarterly reports act as a liaison between the organization and MFCU.

For Fiscal Year 2019, the MCOs opened 23 cases for investigation, terminated 54 providers, and recouped $4,191.13. In addition, the dental MCOs reported two referrals for fraud to OMIG. After investigation, OMIG referred the dentists to MFCU. Both dentists were charged with felony Medicaid Fraud. One dental provider pleaded guilty to a felony count of criminal fraud and paid over $100,000 in restitution and $25,000 in fines. The provider was excluded as a Medicaid provider, and he surrendered his dental license. The other dental provider was also charged with a felony, and has a case pending in circuit court.

Provider-led Arkansas Share Savings Entity (PASSE) Oversight and Collaboration

In March of 2019, the Provider-led Arkansas Shared Savings Entities (PASSEs) became full risk for Tier 2 and Tier 3 behavioral health recipients and all developmentally-disabled recipients. Prior to implementation of the program, OMIG worked with DHS and the PASSEs on the program integrity portions of the agreement to ensure consistency with the Federal Managed Care Final Rule.

Each PASSE has its own Special Investigations Unit to discover fraud, waste, and abuse within its program. OMIG is responsible to oversee and ensure that each PASSE follows the program integrity rules in place. Toward that end, OMIG meets in person with each compliance department four times a year, requires each PASSE to report audits, investigations, sanctions, and a myriad of other data each quarter, and monitors the accuracy of encounter data.

Program and Policy Review

The first quarterly reports submitted to OMIG showed four provider termination actions, one hotline tip, two open investigations, and one recoupment in the amount of $162.00. Moving forward, these numbers will most likely increase since the program is in the beginning stages.

Contract Reviews

One aspect of the OMIG mission is to review contracts funded by Medicaid. The goal in assessing each contract is to ensure compliance with performance-based contracting standards, to review DHS internal controls, and to determine whether DHS takes corrective action when vendors are not in compliance with their contracts.

In Fiscal Year 2019, OMIG reviewed 70 Medicaid-financed contracts. Examples of those agreements include, among others, a third-party liability contractor, a mobile radiology service, actuarial services, and a professional services contract for software installation and configuration.

Controlled Prescription Drug Review

OMIG examines prescriber and dispensing practices through use of data analytics by comparing multiple opioid prescriptions within the same Medicaid household, performing link analysis of high prescribers with recipients and pharmacies, and identifies excessive prescribing practices. The Optum pharmacy contractor conducts audits of identified pharmacies and OMIG reviews prescriber behavior. OMIG works closely with the DHS pharmacy division in review of provider prescribing practices, policy review, and in sharing tools and techniques to assist in identifying issues related to opioid misuse. OMIG assists and supports investigations for federal law enforcement agencies, the Arkansas Department of Health, DHS, the Arkansas Pharmacy Board, Long Term Care Providers, and stakeholders.

In State Fiscal Year 2019, the 92nd General Assembly amended the Prescription Drug Monitoring Program Act allowing OMIG access to the controlled substances database for investigation of fraud, waste, and abuse within the Arkansas Medicaid prescription drug program.

OMIG serves on the Opioid Task Force comprised of state and federal law enforcement agencies, state and federal agencies overseeing provision of health care, and private insurance providers. This group meets biannually to collaborate and share information regarding Opioid initiatives, data analysis trends, and provide best practices to tackle this ever-growing problem.

As a member of the PDO Advisory Workgroup of the Arkansas Alcohol and Drug Abuse Coordinating Council, OMIG assisted in selecting High Needs Communities for 2016 SAMHSA grant funding to reduce prescription drug and opioid overdose-related deaths, behavioral health disparities among racial and ethnic minorities, and implementing a naloxone program.

Contractor Program Integrity Activities

In order to enhance program integrity, OMIG uses a DHS contractor, Optum, and a CMS contractor, Qlarant Integrity Solutions, to assist in performing program integrity functions.

Optum Pharmacy

In State Fiscal Year 2019 OMIG continued its partnership with Optum to conduct pharmacy audits by reviewing documentation on selected pharmacy claims. Optum's analytics team, along with the expertise of a licensed Arkansas pharmacist and pharmacy technician, select pharmacies to perform both desk and onsite reviews. The audit selections are approved by OMIG, and the pharmacies are notified appropriately.

OMIG directed Optum to expand the number of pharmacies audited to comply with the contract deliverables, as a result 218 Pharmacy Providers were audited in State Fiscal Year 2019. Optum selected 19 Pharmacy Providers for an onsite review, and the remaining 199 were selected for a desk review. The request for records (or claims) for the 218 cases totaled 9,727 claims with a total paid amount of $7,185,091.67. At the time this report was prepared, 171 audits had been completed resulting in 2,279 claims with a finding of improper payment and a $2,486,939 total questioned cost reported to OMIG. Since this partnership began in State Fiscal Year 2015, Optum has initiated 755 audits of Pharmacy Providers. These reviews consisted of a total of 25,886 claims totaling $17,109,351 in Medicaid paid claims. The audits resulted in a total of 11,491 claims with a Finding or Observation and as a result Optum has reported a total questioned cost of $5,271,239.70 reported to OMIG. 194 of the cases concluded with no findings which illustrates that many Pharmacies have adequate internal controls to maintain compliance with Medicaid policies.

During State Fiscal Year 2019, Optum submitted two fraud referrals to OMIG related to Pharmacy Providers which identified several credible allegations of fraud. OMIG reviewed the cases and subsequently referred them to MFCU. These are the first cases for any pharmacy providers that have been referred to MFCU in over 20 years by any agency or individual. These providers are currently under investigation.

Contractor Program Integrity Activities

Optum Fraud and Abuse Detection System (FADS)

Optum hosts the Medicaid Enterprise Decision Support System that contains the Fraud and Abuse Detection System (FADS). This software system provides a suite of data extraction tools that OMIG uses to prevent and detect fraud, waste and abuse. The tools in FADS include: Peer Group Profiling, Spike Detection, Query and Report Writing, and Claim Browse and Search.

The key activities conducted through the FADS partnership include:

- On-Site Training in August 2018.
- Optum participated in CMS Certification documentation preparation and presentation in December 2018. CMS issued full certification in March 2019.
- The Optum FADS team upgraded the system by deploying COGNOS 11 in January 2019, along with providing web-based training for OMIG.
- The Optum FADS team conducted a review of suspicious claims for recipients in Long Term Care facilities in December 2018.
- Conducted updates on several FADS reports and components to incorporate dental managed care and PASSE encounter data.

Medicaid Enterprise Certification

Federal law provides for an enhanced Federal match rate up to 90% of the costs to develop and implement an MMIS and 75% of the costs to develop and operate an MMIS. To qualify for this enhanced funding, systems must meet Federal requirements and pass certification by CMS as defined in the Medicaid Enterprise Certification Toolkit (MECT). OMIG staff participated in the CMS onsite certification interview for the Medicaid Enterprise Certification process of the Medicaid Management Information System (MMIS) in December 2018.

OMIG's Program Administrator, Brandy Cook, partnered with Optum staff during the CMS onsite certification review to conduct a live demonstration of the Optum Fraud and Abuse Detection System (FADS). Ms. Cook's demonstration illustrated how these tools fulfill the Program Integrity deliverables required of the Medicaid Enterprise Decision Support System. This presentation was filled with examples of how those tools are integrated into OMIG data mining processes. OMIG showed peer group profiling and how it defines the scope of Provider Awareness Letters, and how OMIG utilizes FADS algorithms to identify providers who may warrant further review. During the interview, CMS auditors applauded OMIG's expertise with the FADS tools and integration of the tools into their Program Integrity data mining practices. The CMS auditors specifically mentioned OMIG's demonstration as an instrumental factor leading to approval of the certification. In March 2018, DHS achieved the certification on the first application with the lowest number of open questions from auditors at the conclusion of the onsite interviews.

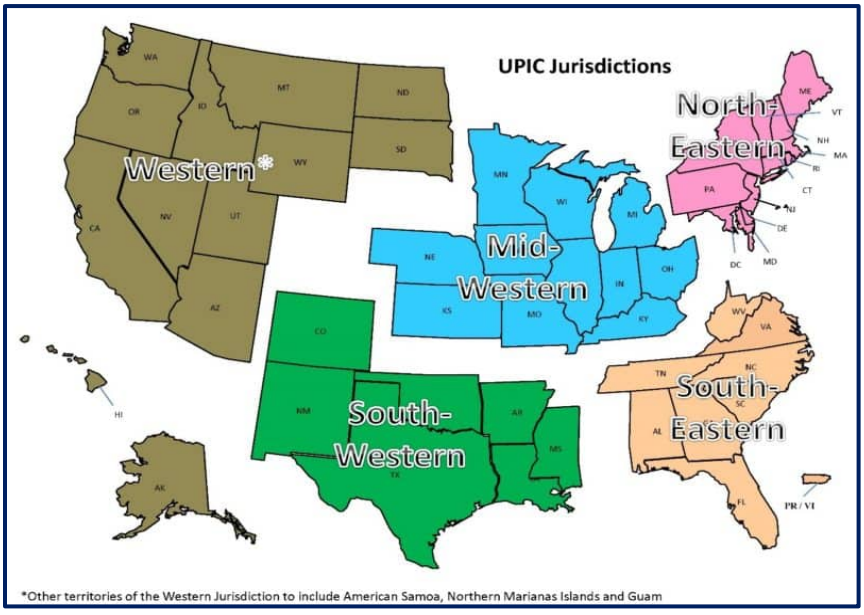
Contractor Program Integrity Activities

Unified Program Integrity Contractor (UPIC)

CMS created the Unified Program Integrity Contractor (UPIC) to combine the functions formerly performed by Medicaid Program Integrity Contractors (MIC) and Zone Program Integrity Contractors (ZPIC) into a single contractor defined by geographic regions.

The UPIC is contracted to perform Medicare and Medicaid program integrity reviews and assistance to enhance state program integrity functions. Arkansas lies within the Southwestern UPIC jurisdiction along with Colorado, Oklahoma, Mississippi, Missouri, New Mexico, and Texas and is served by Qlarant Integrity Solutions.

During State Fiscal Year 2019, Qlarant provided data analysis on two Medicare-Medicaid match projects: coordination of benefits voids and Pharmacy duplicate payments. Qlarant has also provided data analysis and policy research to support fraud investigations.



Initiatives

Provider Awareness Letters (PALs)

OMIG has been recognized as a national leader in innovation for Program Integrity practices. OMIG is continually building upon and expanding its focus on provider outreach and education by developing strategies that create the greatest return on investment and reducing provider burden while increasing program integrity. Provider Awareness Letter (PAL) Initiatives continue to serve as a valuable mechanism to effectively correct behaviors across a range of provider groups and identify areas for improvement in the Medicaid program. Cost avoidance opportunities continue to develop while identifying cost-effective ways to maximize the use of agency resources to detect and combat fraud, waste, and abuse. Rather than OMIG conducting full scale audits of these providers, the letters allow OMIG to utilize fewer resources to reach more providers efficiently, creating a positive return on investment. The FADS Peer group profiling tool is used to identify providers who deviated significantly from their peers for potentially aberrant billing behaviors. To verify the billing pattern is improper and to establish a baseline, OMIG audits the most egregious. After review of the audit results, PALs are sent to the remaining outlier providers asking for a self-review of those claims. OMIG expects the provider to self-disclose improper payments, return those funds, and correct the billing behavior going forward which results in cost avoidance. When a provider response does not meet expectations, a full scale audit is performed in order to verify OMIG's assumptions.

- **False Claims Act Compliance**

OMIG completes False Claims Act Compliance Reviews annually of all providers who receive at least $5 million dollars in Medicaid reimbursement per Federal Fiscal Year to ensure compliance with §6032 of the Deficit Reduction Act, and Social Security Act, §1902(a) (68). These providers are required to develop a compliance plan which includes internal control policies and procedures for detecting and preventing fraud, waste, and a discussion of the rights of whistleblowers. OMIG performed 135 False Claims Act Compliance Reviews during State Fiscal Year 2019.

- **Locum Tenens Billing**

When a physician must leave his/her practice due to illness, vacation, or medical education opportunity, the Medicaid Physician Provider Manual allows an arrangement for a substitute "Locum Tenens" provider for up to 60 days. Based on a complaint received by OMIG from the Department of Human Services, OMIG analyzed Medicaid claims for providers utilizing Locum Tenens. OMIG sent provider awareness letters regarding 2,412 claims utilizing Locum Tenens in lieu of audit. OMIG educated the providers of the proper use of Locum Tenens and requested the provider disclose improperly billed claims. As a result of this initiative, over $30K was identified for recovery.

Initiatives

Hospital One Day Stay

In State Fiscal Year 2019, OMIG continued the review of hospital inpatient claims for services less than 24 hours, or "one day stays". The criteria for this review excluded hospital stays with an observation or outpatient stay before the admission and/or discharge date on an outpatient claim. Self-audits were requested by OMIG and performed by the identified providers resulting in $8,416.00 being reported and returned to the Arkansas Medicaid Program. OMIG will continue this initiative in State Fiscal Year 2020.

Recoupment Letters

Provider Recoupment Letters are submitted when OMIG is confident that an improper claim has been submitted and resulted in an overpayment. In these instances, there is no fraud suspected and no system edit in place to avoid these claims, OMIG notifies the provider of the issue and that the claims will be subject to recoupment.

Provider recoupment letters that were submitted in State Fiscal Year 2019:

- Services After Death
- Medicare-Medicaid Coordination of Benefits Review
- Duplicate Refraction
- HCBS and Inpatient Overlap
- NCCI PTP Edits

Services After Death

OMIG regularly conducts data analysis to identify services billed after death. Over the last several years, OMIG's analysis has resulted in recoupments and recommendations to DHS regarding inaccuracies in the recipient data. OMIG conducted a desk review of claims paid for 107 Medicaid providers who billed for services that occurred after the recipient's reported date of death. The initiative resulted in a mass adjustment with a recoupment of $7,841.35.

Going forward, the new MMIS InterChange System has integrated the ability to recognize these inaccurate payments and recover them automatically. OMIG will monitor the recovery of these payments to ensure the business rules regarding these payments are being followed.

Medicare-Medicaid Coordination of Benefits Review (Crossovers)

Medicaid crossover payments occur when a beneficiary is eligible for both Medicare and Medicaid coverage. Pursuant to the Arkansas Medicaid Manual §332.300, if any Medicare payment source makes an adjustment that results in an overpayment or underpayment by Medicaid, the provider must submit an adjustment for recoupment or reversal.

Initiatives

OMIG partnered with Qlarant, the Arkansas Unified Program Integrity Contractor to identify the crossover payments from voided or reversed Medicare claims.

In April 2019, OMIG reviewed Medicaid crossover claims paid for dates of service from November 1, 2016 through December 31, 2018. Based on that review, OMIG recovered $222,530.04 in Medicaid crossover payments in which the Medicare claim had been voided or reversed. In State Fiscal Year 2020, OMIG will continue its review of paid Arkansas Medicaid claims affected by the void or reversal of an associated Medicare claim in order to recover improper payments.

- **Duplicate Refraction Procedures**

OMIG performed a lookback review for compliance with prior fiscal years' education on billing duplicate refraction procedures. OMIG identified multiple instances in which vision providers submitted duplicate refraction exam claims by submitting a refraction procedure on the same date of service as a comprehensive ophthalmological exam, which includes refraction.

The Visual Care-Arkansas Medicaid Provider Manual states that HCPCS code S0620 and S0621 may be billed when a routine ophthalmological examination includes a refraction exam performed for a new or established patient. The CPT code 92015 may be billed for determination of refractive state, but must be performed alongside a medical exam. As HCPCS codes S0620/S0621 and CPT code 92015 both cover refraction exams, it is improper for a provider to bill both codes for the same beneficiary on the same date of service.

In State Fiscal Year 2019, OMIG identified additional improper claims subsequent to the first educational opportunity. The review revealed 24 providers who billed these procedures improperly. OMIG sent recoupment letters to those vision providers and recouped $7,230.72.

- **NCCI PTP Edits**

The Patient Protection and Affordable Care Act (H.R.3590) §6507 (Mandatory State use of National Correct Coding Initiative) (NCCI) requires state Medicaid programs to incorporate NCCI methodologies into their claims processing system. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported.

OMIG data analysis identified $136,397.14 in overpayments from NCCI Procedure-to-Procedure edits, which are Current Procedural Terminology (CPT) code pairs that generally should not be billed together. OMIG sent out 164 recoupment letters for claims with dates of service spanning from January 1, 2015 to October 1, 2017. As a result of this initiative, OMIG identified MMIS system deficiencies that allowed these payments to occur and reported those to DHS. OMIG is monitoring the MMIS to enforce the NCCI edit methodologies going forward.

Initiatives

Home and Community Based Services Inpatient Overlap

Personal Care services are historically known as an arena for Medicaid fraud. Over the past few years, OMIG has performed focused reviews of the Home and Community Based Services policies as well as provider billing behavior. OMIG has educated providers and worked with DHS on implementation of safeguards. This year, OMIG continued its review of personal care services using data analysis to identify 609 claims paid for Home and Community Based Services (HCBS) during the same time those Medicaid Beneficiaries were treated in an Inpatient Facility from July 1, 2017 to July 5, 2018. When a Medicaid Beneficiary is in a hospital or other inpatient facility, Home and Community Based Services obviously are not necessary and also not reimbursable. In some instances, HCBS claims are submitted by mistake, however billing for services not provided constitutes fraud. While the reimbursement for these hourly services is low, however this population of recipients is vulnerable to Medicaid fraud as these services are typically provided in the home with little direct oversight. OMIG sent 102 recoupment letters to HCBS providers based on this review. OMIG has recovered $35,108.89 and referred 7 personal care providers and 2 Medicaid Recipients to MFCU.

Medicare – Medicaid Duplicate Pharmacy Payments

In State Fiscal Year 2019, OMIG identified, through data analysis, overpayments concerning Medicaid Beneficiaries who were Medicare Part-D eligible and enrolled in a long-term care facility from January 1, 2015 to September 30, 2017. The data examination was based on a sample of paid claims with the same beneficiary, national drug code number, and dates-of-service. Duplicate payments from Medicare and Medicaid were identified. This Medicaid Rule is based on §212.000(b) and 212.000(c) of the Pharmacy-Arkansas Medicaid Provider Manual.

OMIG sent 17 recoupment letters in State Fiscal Year 2019 from this data review resulting in $20,494.34 recoupment to date. This initiative will continue during State Fiscal Year 2020.

Provider Community Engagement & Staff Enrichment

Conferences & Workshops

The Inspector General and other OMIG personnel have conducted presentations and provided training at multiple conferences and seminars throughout the year. These appearances include the Home Care Association of Arkansas, the Program Integrity Director's Symposium, the Arkansas Ambulance Association's Annual EMS Expo, the Medicaid Integrity Institute, and other healthcare-related groups and state agencies. In addition, OMIG personnel have also participated in online webinars related to behavioral health billing and the PASSEs.

OMIG will continue to provide training and assistance to Medicaid providers and staff as part of the overall mission to educate and identify fraud, waste, and abuse in the Arkansas Medicaid Program. OMIG's educational outreach has enhanced Medicaid Program Integrity compliance, and increased provider self-reports of improper payments.

NAMPI

In August 2018, Medicaid Inspector General Elizabeth Smith spoke at the National Association for Medicaid Program Integrity (NAMPI) conference in Austin, TX. She presented an overview of the benefits and challenges associated with implementing CMS recommendations contained in "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services," the white paper released by CMS the previous year. Inspector General Smith also presented "Cost Avoidance Strategies to Drive Value from Data Analytics." Smith educated attendees on how to conduct PALs and highlighted the value and success of OMIG PALs as a non-traditional technique to bring savings and strengthen integrity in State Medicaid agencies.

Continuing Education

Throughout the year, OMIG staff has attended local and national conferences pertaining to program integrity, Medicaid policy, vendor contracts, and Arkansas Medicaid programs. OMIG staff members continue to attend training courses and other symposiums held by the Center for Medicare and Medicaid Services' Medicaid Integrity Institute (MII). These courses are provided to qualified state employees and are 100% funded by the federal government.

In State Fiscal Year 2019, eight OMIG personnel attended and completed 11 courses at the MII. OMIG employees successfully achieved certification as a Program Integrity Professional and completed training in fundamental coding, auditing, investigating, program integrity, and coding evaluation and management. These certifications and trainings strengthen the credibility of our staff and aides in communication among auditors, data analysts, investigators, and other medical professionals. The collaboration and knowledge shared during these courses enhances Medicaid program integrity by providing innovative ideas and tools to assist in detection and prevention of fraud, waste, and abuse in the Medicaid program.