



Office of Compliance and Program Integrity

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Objectives:

- **Providers will have a better understanding of fraud, waste and abuse**
- **Providers will have knowledge how referrals are made to OCPI**
- **Providers will have a better understanding of a post payment review**
- **Providers will have a better understanding of pre-payment review**

- **OCPI's Vision:**
 - **Ensures the North Carolina's Medicaid Program delivers intended results**

- **OCPI's Mission:**
 - **Protecting the resources of DMA by reducing or eliminating fraud, waste and abuse through the NC Medicaid program.**

- **OCPI's Values:**
 - **Accountability**
 - **Integrity**
 - **Collaboration**
 - **Innovation**
 - **Communication**

Office of Compliance and Program Integrity

- Code of Federal Regulations 42 CFR 455 Federally Mandates OCPI to:
 - Prevent,
 - Identify, and
 - Investigate potential fraud, waste, and abuse within the Medicaid Program

***In NC, Possible fraud is referred to NC Medicaid Investigations Division (AGO/MID)*

- Ensure Medicaid funds are utilized appropriately
 - OCPI identifies and investigates for possible payment error, overutilization, medically inappropriate services
- Protect the “Integrity” of the Medicaid Program

OCPI Chain of Authority

- **Federal Regulations 42 CFR 455**
 - **Medicaid and Health Choice regulations are in Title 42 (Public Health) of the CFR**
 - **Medicaid are in Parts 420s-430s**
 - **Health Choice are in parts 440s-450s**
- **North Carolina General Statutes 108C**
 - **Medicaid and Health Choice Provider Requirements**
- **Medicaid State Plan**
- **North Carolina Administrative Code 10A NCAC 22F**
- **State Clinical Policies (PCS Clinical Coverage Policy 3L)**
- **Bulletin Articles**

10A NCAC 22F .0302 INVESTIGATION

OCPI shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of a case from among the following administrative actions:

- 1. To place provider on probation with terms and conditions for continued participation in the program.**
- 2. To recover in full any improper provider payments.**
- 3. To negotiate a financial settlement with the provider.**
- 4. To impose remedial measures to include a monitoring program of the provider's Medicaid practice terminating with a "follow-up" review to ensure corrective measures have been introduced.**
- 5. To issue a warning letter notifying the provider that he must not continue his aberrant practices or he will be subject to further division actions.**
- 6. To recommend suspension or termination.**

**** If the investigative findings show that the provider is not licensed or certified as required by federal and state law, then the provider cannot participate in the North Carolina State Medical Assistance Program (Medicaid).**

What is Fraud?

Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.



Examples:

- Filing false claims
- Falsifying/fabricating medical documents
- Soliciting/receiving/offering payments for referrals

ALL Credible allegation of /or suspected fraud are referred to the NC Medicaid Investigations Division



- **Potential for suspension of payments**
- **Potential for prepayment review or other administrative sanctions affecting continued participation**

What is Abuse?

- **Provider practices that are inconsistent with sound fiscal, business or medical practice and result in an unnecessary cost to the Medicaid program**
- **Also includes recipient practices that result in unnecessary cost to the Medicaid program**

Examples of Abuse

- **A provider may be billing separately for items that should be bundled into one supply package.**
- **Billing for unnecessary medical services**
- **Charging excessively for services or supplies**
- **Misusing codes on a claim**

OCPI Referral Source

- **Complaints**
 - **Beneficiaries, public, providers**
- **Referrals from formal sources**
 - **Regulatory agencies,**
 - **DSS,**
 - **DHHS partners,**
 - **DMA program consultants,**
 - **CMS,**
 - **OSA**

Post Payment Review

Onsite Review Announced

Provider is given advance notification of OCPI site visit via:

- fax
- telephone call
- email



(#days advance notice may vary per scope of review)

Post Payment Review

Onsite Review Unannounced

- PI or Post Pay Contractor arrives on day of review to provider site (no prior fax, letter, phone call or email)
- Introductory Discussion with Provider Management
- Staff Introduction & Introductory “Letter”
- Medical Records Request
- Intro to Provider Files & Setup of PI Staff
- Exit Discussion per Scope of Review



OCPI's Goal - As Minimally Disruptive as Possible

OCPI Desk Review

- Provider is notified of review via written request for records
- Time Frame and Instructions for Submission
- PI or Contractor Contact
- General Description of Matters Subject to Review
- Currently Most Frequent Method of Post Pay Review

Certified Mail is most frequent method of contact

**PI uses correspondence address listed in
NCTRACKS**

Post Payment Review Outcome

- No errors, may close case
- Payment error less than \$150.00 may receive an education letter
- Overpayment

Pre-Payment Review

- **Purpose** is to ensure that provider's claims meet the requirements of federal and State laws/regulations and medical necessity criteria
 - For any claims in which the Department has given prior authorization, prepayment review shall not include review of the medical necessity for the approved services.
- Provider claims may be subject to prepayment review due (but not limited) to:
 - Credible allegation of fraud
 - Identification of aberrant billing practices as a result of data analysis or investigations, or
 - Other grounds as listed by the Department in rule.

Pre-Payment Review

- Provider Notice of Prepayment Review Must Occur no less than 20 calendar days prior to initiating prepayment review.
- The notice of prepayment review will include:
 - the reason (s) for prepayment review,
 - the type of claims (may be limited to certain code) subject to review & include standards by which claims are reviewed
 - Include process explanations, provider instructions & explain claim review time frames
 - which records are requested, how to submit and time limits for submission

Pre-Payment Review

- Similar to the Desk Review, the prepayment reviewer receives provider's supporting documentation and:
 - Determines if provider submitted entirety of requested records
 - Makes determination whether provider's documentation supports claim details
 - Makes determination whether provider's documentation supports program compliance
 - Reviews Clinical coverage policy applicable to DOS under review
 - Applicable laws, regulations

Contact Information

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Questions

