



Inspector General Administration

Al Kimichik, Inspector General

DME Provider Liaison Meeting

Matthew Chodak, PEB Field Agent

Jacob Kwasneski, PEB Field Agent

March 7, 2016





Introduction





MDHHS-IGA

Michigan Department of Health and Human Services
Inspector General Administration





FAQ

W.A.T.G.





To The Next Question:





Once there was OHSIG . . .

Michigan's Former Governors

Former Governors Home

Jennifer Granholm 2003-2011
Governor Granholm Executive Orders
Executive Directives
Press Releases
Speeches
John Engler 1991-2002

FORMER GOVERNORS / JENNIFER GRANHOLM 2003-2011 / GOVERNOR GRANHOLM EXECUTIVE ORDERS

EXECUTIVE ORDER No. 2010 - 1

CREATION OF OFFICE OF HEALTH SERVICES INSPECTOR GENERAL DEPARTMENT OF COMMUNITY HEALTH EXECUTIVE REORGANIZATION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 2 of Article V of the Michigan Constitution of 1963 empowers the Governor to make changes in the organization of the executive branch of state government or in the assignment of functions amongst its units that the Governor considers necessary for efficient administration;

WHEREAS, fraud, waste, and abuse in the state's health services programs affect all Michigan citizens by increasing health care costs and by undermining the trust of taxpayers funding the program;

WHEREAS, the current fraud, waste, and abuse control activities conducted by the Department of Community Health have been successful in recouping, withholding, or avoiding unnecessary spending;

WHEREAS, notwithstanding the success of these efforts, the current system would benefit from consolidation of fraud, waste, and abuse responsibilities and increased focus on specific auditing and fraud prevention goals;

WHEREAS, further reduction in fraud, waste, and abuse in the state's health services programs will benefit this state and Michigan taxpayers;

WHEREAS, the State of Michigan should safeguard taxpayer dollars by using innovative strategies to reduce fraud, waste, and abuse in health services programs;

WHEREAS, there is a continuing need to reorganize functions amongst state departments to ensure efficient administration and effectiveness of government;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS

As used in this Order:

A. "Children's Special Health Care Services Program" means the program for medical assistance for mothers and children provided under Part 58 of the Public Health Code, 1978 PA 368, MCL 333.5801 to 333.5879, including the program for medical assistance for mothers and children established under the Title V of the federal Social Security Act, 42 USC 701 to 710.

B. "Civil Service Commission" means the commission required under Section 5 of Article XI of the Michigan Constitution of 1963.

C. "Department of Community Health" or "Department" means the principal department of state government created as





Now there is the IGA

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

BRIAN CALLEY
LT. GOVERNOR

EXECUTIVE ORDER No. 2015 - 4

CREATION OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
MICHIGAN CHILDREN'S SERVICES AGENCY,
AGING AND ADULT SERVICES AGENCY,
AND THE HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HUMAN SERVICES
DEPARTMENT OF COMMUNITY HEALTH
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

EXECUTIVE REORGANIZATION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the state of Michigan in the Governor; and

WHEREAS, Section 2 of Article V of the Michigan Constitution of 1963 empowers the Governor to make changes in the organization of the Executive Branch or in the assignment of functions among its units that he considers necessary for efficient administration; and

WHEREAS, Section 8 of Article V of the Michigan Constitution of 1963 provides that each principal department shall be under the supervision of the Governor unless otherwise provided by the Constitution; and

WHEREAS, there is a continued need to reorganize functions among state departments to ensure efficient administration; and

WHEREAS, the protection and strengthening of Michigan's families can be more effectively and efficiently assured by the alignment of family and health related services and administrative functions in state government;

NOW, THEREFORE, I, Richard D. Snyder, Governor of the state of Michigan, by virtue of the powers and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

GEORGE W. ROMNEY BUILDING • 111 SOUTH CAPITOL AVENUE • LANSING, MICHIGAN 48909





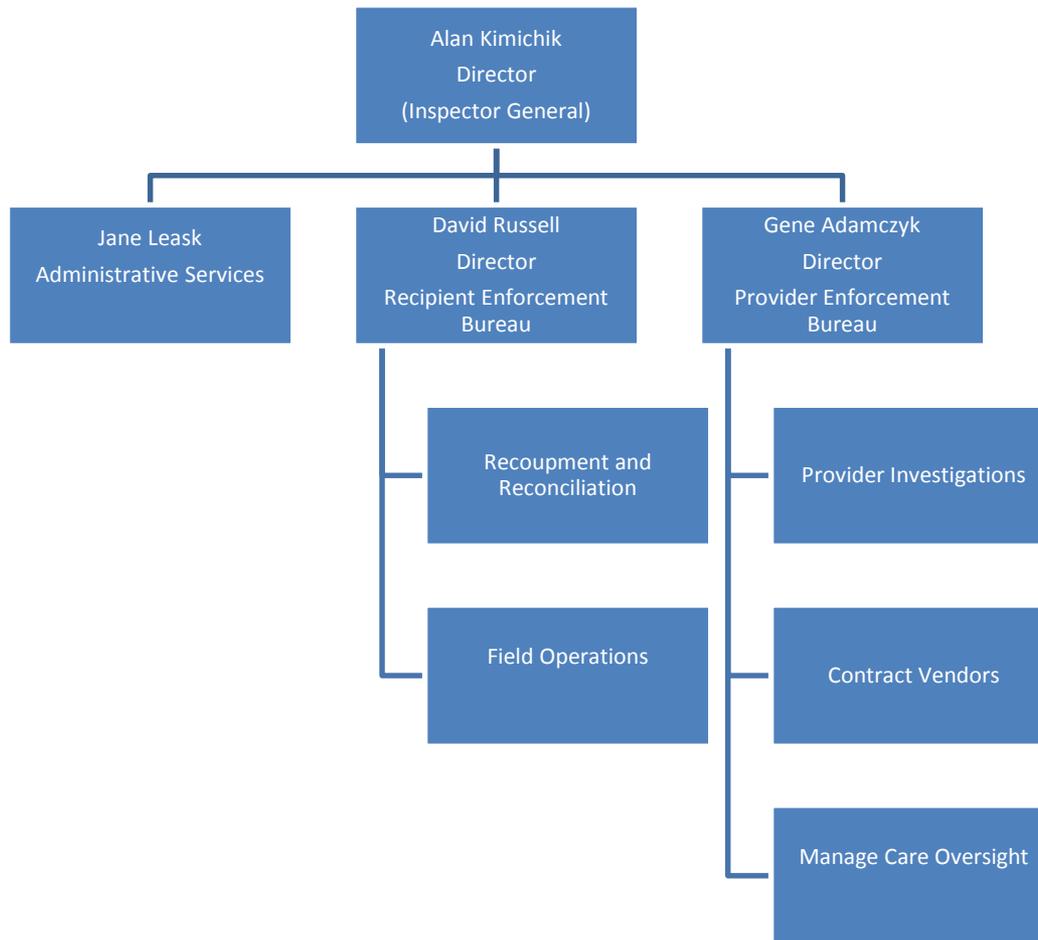
History of The IGA

- Originally, the IGA was two separate departments: Department of Community (DCH) Health and Department of Human Services (DHS) .
- Previously, the Office Health Services Inspector General (OHSIG) was part of DCH.
- DCH and DHS were combined in 2015 by Executive Order of Gov. Snyder.





IGA Organization Chart





Two Branches of Enforcement

Provider Enforcement Bureau (PEB)

The former Office of Health Services
Inspector General

Recipient Enforcement Bureau (REB)

The former Department of Human Services
Office of Inspector General + Recoupment
and Reconciliation





PEB

- This the side of the IGA that focuses on Medicaid Providers.
- Conducts audits, spot checks and enforcement.
- If you believe Fraud, Waste and /or Abuse (FWA) is taking place with a provider and you report it, this is the division you will be working with.





REB

- This the side of the IGA that focuses on Recipients.
- This division deals with mainly Medicaid FWA committed by recipients.
- If you believe this is taking place and you report it, this is the division you will be working with.





How to report FWA.

- Contact our hotline at:
- 855-MI-FRAUD
- Fraud referral online via our website:
- http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-220188--,00.html
- OIG PEB Main Phone Line: 1-866-428-0005





Reporting Fraud

- Reporting is required when you have a suspicion of fraud or abuse!!!
- *The contractor shall not attempt to investigate or resolve the reported alleged fraud and/or abuse.*
- This is your contractual obligation.





IGA goal:

Enforcement that also creates a more LPF.





How to Guard Against FWA

- Maintain accurate and complete medical records that include complete intake, diagnosis, plans of care, and supporting documentation.
- Bill for services rendered in accordance with published guidelines, not merely selecting the code with the most favorable reimbursement.
- Obtain prior authorization when required.
- Review the background of all providers and workers.
- Develop internal policies and compliance programs which review your operations on an ongoing basis.
- When in doubt, be conservative!





What is Fraud?

- Fraud includes obtaining a benefit through intentional misrepresentation or concealment of material facts, as well as refusal to amend practices identified as aberrant or identified as improper. This includes deliberate ignorance or reckless disregard of the truth.
- Fraud = Intent
- Example: Billing for services/products not delivered.





What is Waste?

- Waste includes incurring unnecessary costs as a result of lack of knowledge or deficient management, practices, and controls.
- Example: Providing a beneficiary with an amount of product in excessive quantities.





What is Abuse?

- Abuse includes excessively or improperly using government resources.
- *Example: Getting multiple beneficiaries signed up for Medicaid at same address and still billing for multiple mileages. ????*







Trends in Fraud.

- Federal estimates place Medicaid and Medicare fraud at anywhere from 3% - 10%.
- Healthcare FWA is a serious problem nationally and particularly in Michigan, which hosts one of the nation's 9 Health Care Fraud Prevention and Enforcement Action Teams (HEAT).





- June 2015 - A joint initiative between the DOJ and Heat Teams resulted in a nationwide Medicare Fraud Strike Task Force take down with charges against 243 individuals involving \$712 million in Medicare Fraud Claims.





Fraud Scheme

JUSTICE NEWS

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE

Tuesday, February 24, 2015

Former Owner of Durable Medical Equipment Company Pleads Guilty in \$5 Million Health Care Fraud Scheme

A Miami man pleaded guilty today to health care fraud charges in connection with a \$5 million scheme to defraud Medicare.

Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, U.S. Attorney Wifredo A. Ferrer of the Southern District of Florida, Special Agent in Charge Derrick Jackson of the U.S. Department of Health and Human Services Office of Inspector General's (HHS-OIG) Miami Field Office, Special Agent in Charge Mike Fields of HHS-OIG's Dallas Field Office, Special Agent in Charge Paul Wysopal of the FBI's Tampa Field Office, and Special Agent in Charge Perry K. Turner of the FBI's Houston Field Office made the announcement.

Angel M. Mirabal, 62, of Miami, Florida, pleaded guilty to one count of conspiracy to commit wire fraud and health care fraud before U.S. District Judge Marcia G. Cooke of the Southern District of Florida. A sentencing hearing is scheduled for May 6, 2015.

In connection with his guilty plea, Mirabal admitted that he was the owner, president and manager of Quick Solutions Medical Supplies Inc. (Quick Solutions), a durable medical equipment (DME) supply company located in Houston, Texas. Mirabal further admitted that from April 2010 through July 2013, he and his co-conspirators operated Quick Solutions for the purpose of billing the Medicare program for, among other things, expensive DME that was medically unnecessary and in many instances not provided to the Medicare beneficiaries. Indeed, many of the beneficiaries who purportedly received the DME resided hundreds of miles away in Miami.

From June 2011 through February 2012, Quick Solutions submitted approximately \$5 million in fraudulent claims, and Medicare paid approximately \$587,900 for these claims.

This case was investigated by the FBI, HHS-OIG and Texas Attorney General's Medicaid Fraud Control Unit, and was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and U.S. Attorney's Office for the Southern District of Florida. This case is being prosecuted by Trial Attorney Timothy P. Loper of the Criminal Division's Fraud Section.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged nearly 2,100 defendants who have collectively billed the Medicare program for more than \$6.5 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

To learn more about the Health Care Fraud Prevention and Enforcement Team (HEAT), go to: www.stopmedicarefraud.gov.

15-224
Healthcare Fraud

Criminal Division
Updated February 24, 2015





“... he and his co-conspirators operated Quick Solutions for the purpose of billing the Medicare program for, among other things, expensive DME that was medically unnecessary and in many instances not provided to the Medicare beneficiaries. Indeed, many of the beneficiaries who purportedly received the DME resided hundreds of miles away in Miami.”





JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Friday, March 20, 2015

Owner of Medical Equipment Supply Company Convicted for \$3.5 Million Medicare and Medi-Cal Fraud Scheme

A jury in federal court in Los Angeles convicted the former owner of a durable medical equipment supply company of health care fraud charges in connection with a \$3.5 million Medicare and Medi-Cal fraud scheme.

Assistant Attorney General Leslie R. Caldwell of the Justice Department's Criminal Division, Acting U.S. Attorney Stephanie Yonekura of the Central District of California, Special Agent in Charge Glenn R. Ferry of the U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) Los Angeles Region, Assistant Director in Charge David Bowdich of the FBI's Los Angeles Field Office, and Special Agent in Charge Joseph Fendrick of the California Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse made the announcement.

Sylvia Walter-Eze, 48, of Stevenson Ranch, California, was convicted of one count of conspiracy to commit health care fraud, four counts of health care fraud, and one count of conspiracy to pay and receive illegal kickbacks. Sentencing is scheduled for June 15, 2015, before U.S. District Judge R. Gary Klausner of the Central District of California.

The evidence at trial demonstrated that Walter-Eze, the then-owner of Ezcor Medical Supply, paid illegal kickbacks to patient recruiters in exchange for patient referrals. The evidence further showed that Walter-Eze paid kickbacks to physicians for fraudulent prescriptions, primarily for medically unnecessary—but expensive—power wheelchairs, that she then used to support her fraudulent bills to Medicare and Medi-Cal.

Between 2007 and 2012, Walter-Eze submitted \$3,521,786 in claims to Medicare and Medi-Cal, and received \$1,939,529 in reimbursement for those claims.

The case was investigated by the FBI, HHS-OIG's Los Angeles Regional Office and the California Department of Justice, and was brought as part of the Medicare Fraud Strike Force, supervised by the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Central District of California. The case was prosecuted by Trial Attorneys Blanca Quintero and Alexander F. Porter of the Criminal Division's Fraud Section.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged nearly 2,100 defendants who have collectively billed the Medicare program for more than \$6.5 billion. In addition, HHS's Centers for Medicare & Medicaid Services, working in conjunction with HHS-OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

To learn more about the Health Care Fraud Prevention and Enforcement Action Team (HEAT), go to:

www.stopmedicarefraud.gov.

15-352
Healthcare Fraud

Criminal Division
Updated March 20, 2015





“The evidence at trial demonstrated that Walter-Eze, the then-owner of Ezcors Medical Supply, paid illegal kickbacks to patient recruiters in exchange for patient referrals. The evidence further showed that Walter-Eze paid kickbacks to physicians for fraudulent prescriptions, primarily for medically unnecessary—but expensive—power wheelchairs, that she then used to support her fraudulent bills to Medicare and Medi-Cal (Medicaid).”





COMMON INVESTIGATIVE METHODOLOGIES

- Audits of records and specific services.
- Interviews of beneficiaries, providers, relatives, or anyone that might have relevant information
- Subpoena of records (IG can ask for all types of records not just Medicaid, but also Medicare, PHP and uninsured).
- Remember: HIPPA is not a shield from providing the requested documents.





- Site visits
- Data Analysis of Medicaid claims (FFS and ENC)
- Surveillance of facilities
- Random Checks
- Referrals!!!





Findings:

- Records complete and without any errors.

OR

- Errors in patient type and coding.
- Incomplete medical documentation.
- Identity theft.
- Use of provider numbers without knowledge or authorization.





CONSEQUENCES OF VIOLATION:

- Suspension or Termination from participation in the Michigan Medicaid Program
- Payment Denial
- Monetary Penalties in addition to restitution
- Probation or Limited Participation in the Michigan Medicaid Program
- Pre-payment review
- Subjected to additional documentation requirements
- Criminal Penalties including incarceration





Michigan Department of Health and Human Services

Medicaid Provider Manual



SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

The basis for termination or denial of enrollment includes, but is not limited to:

- Failure to submit timely and accurate information;
- Failure to cooperate with MDHHS screening methods;
- Conviction of a criminal offense related to Medicare, Medicaid, or the Title XXI program in the last 10 years;
- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state;
- Failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
- Failure to permit access to provider locations for site visits;
- Falsification of information provided on the enrollment application; or
- Inability to verify a provider applicant's identity.
- Failure to comply with Medicaid policies regarding billing Medicaid beneficiaries.

Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDHHS to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a subsequent re-enrollment application.

Summary suspension prevents further payment after a specified date, regardless of the date of service (NOS)





Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS.).

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:

- An evaluation of billing practices.
- The prior authorization (PA) process.
- An on-site review of financial and medical records and a written report of this review is filed.
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- A peer review of services or practices.

Version
Date: July 1, 2015

General Information for Providers

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Michigan Department of Health and Human Services

Medicaid Provider Manual



- A hearing or conference between MDHHS and the provider (and counsel, if so requested).
- Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- May violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.
- May violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.





We are not:



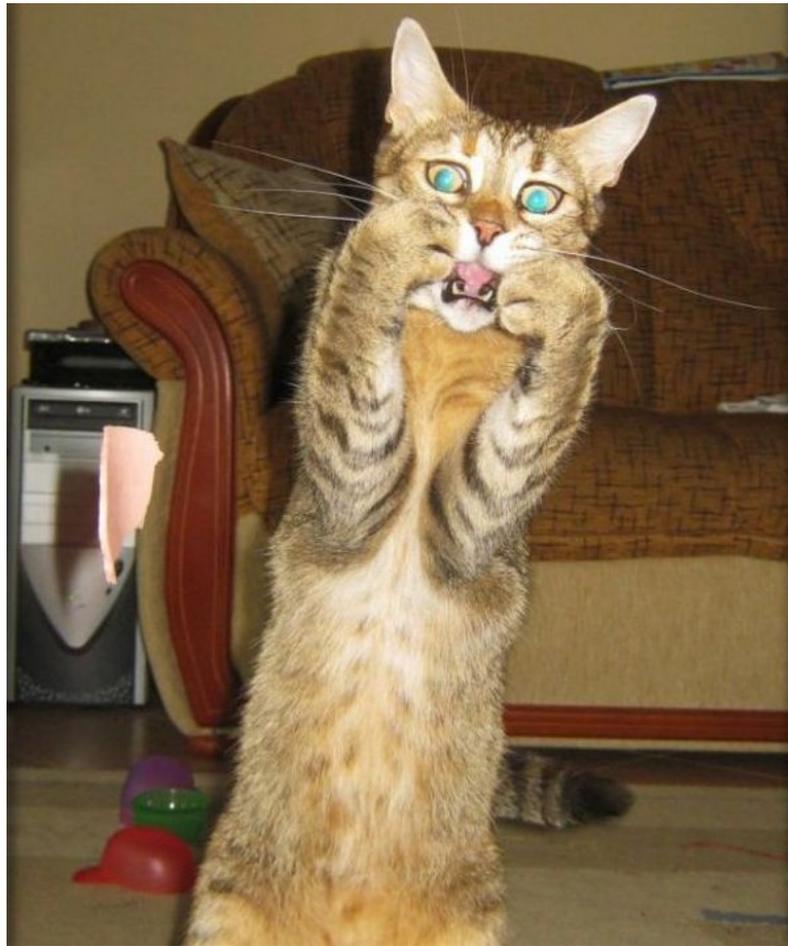


We are more of the friendly sheriff.





So you need not panic!!!





Questions?





Contact Information

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