Protecting Program Integrity

The Texas Health and Human Services Office of Inspector General

March 4, 2025

Texas Health and Human Services
Raymond Charles Winter, Inspector General

OIG Vision & Mission

Vision

- Promoting the health and safety of Texans by protecting the integrity of state health and human services delivery.

Mission

- 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.

Values

Accountability	Integrity
Collaboration	Excellence

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The Toll of Fraud, Waste and Abuse

The National Health Care Anti-Fraud Association estimates that up to **10%** of total health care expenditures are lost to fraud each year. Meaning that in Texas, up to **$5 billion** are siphoned away from their intended purpose.

Every dollar not spent as intended by the Legislature is a dollar lost to taxpayers and not delivered to Texas HHS clients.

Dealing with the Government

“Men must turn square corners when they deal with the Government.”

- Supreme Court Justice Oliver Wendell Holmes, Rock Island, Ark. & LA RR Co. v. United States, 1920

“There is no kind of dishonesty into which otherwise good people more easily and frequently fall than that of defrauding the government.”

- Benjamin Franklin, 1767

OIG Jurisdiction

People and programs

People

- Medical providers.
- Managed care organizations.
- Program clients.
- Program retailers.
- HHS contractors, employees and programs.

Programs

- $50 billion (state and federal) appropriation covering all Health and Human Services system and DFPS programs.
  - Medicaid ($38 billion state and federal appropriation).
  - Supplemental Nutrition Assistance Program (SNAP).

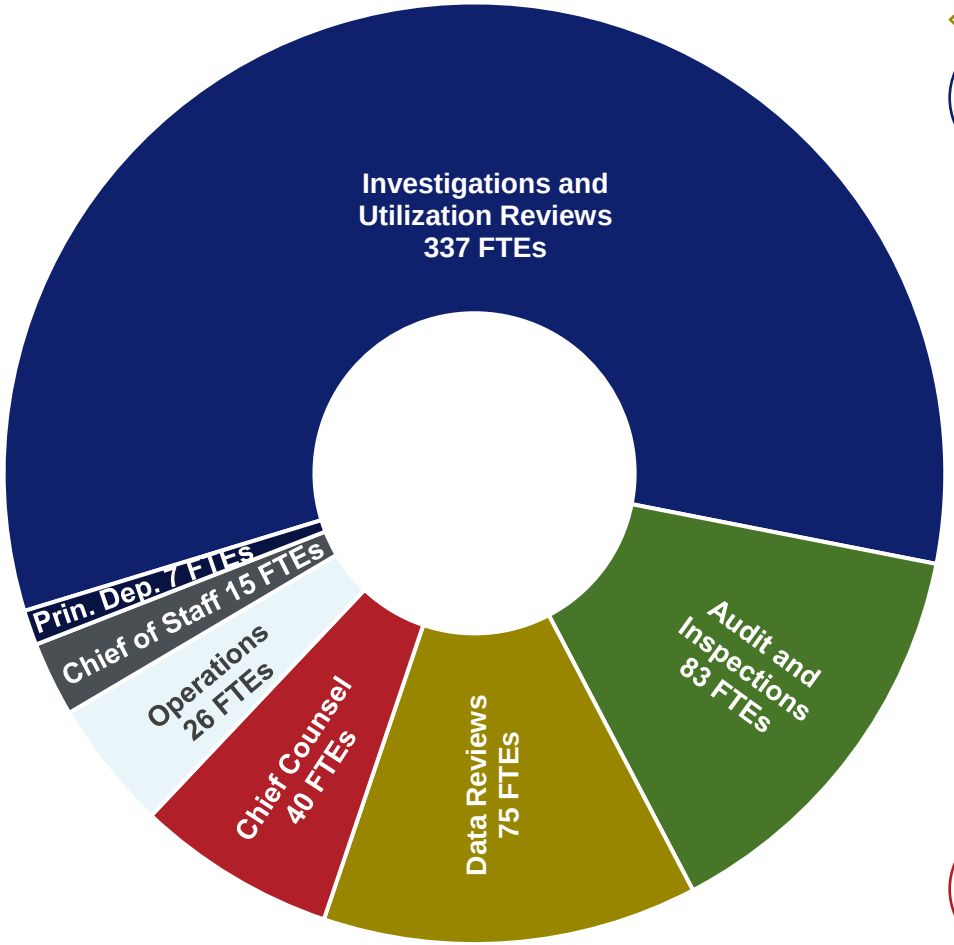
Our Team

Overview

591 FTEs

25 Locations

OIG Toolkit



- Investigations
- Reviews
- Audits
- Inspections
- Data Analysis
- Litigation

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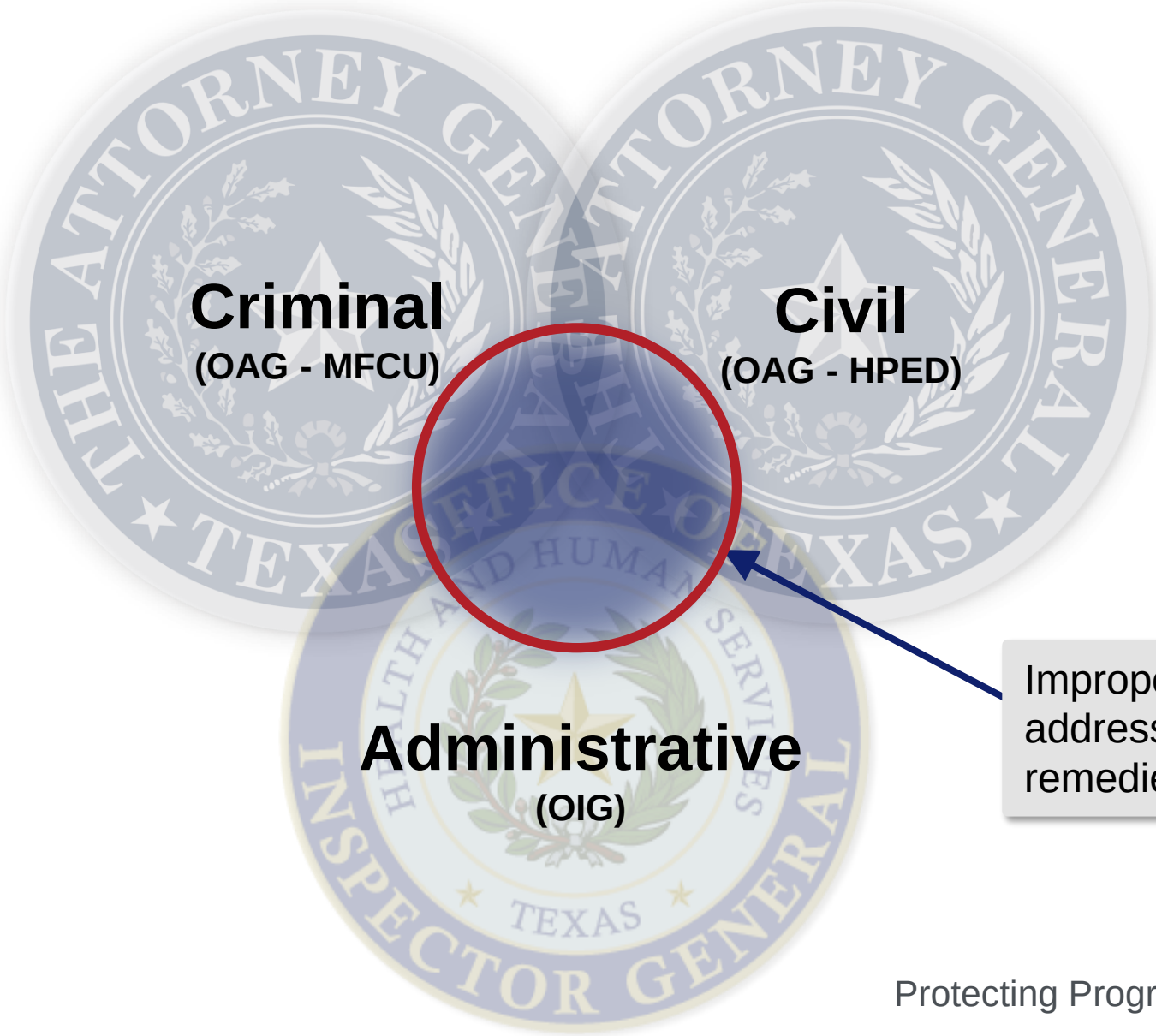
State Agency Collaboration



Improper conduct can be addressed with multiple remedies.

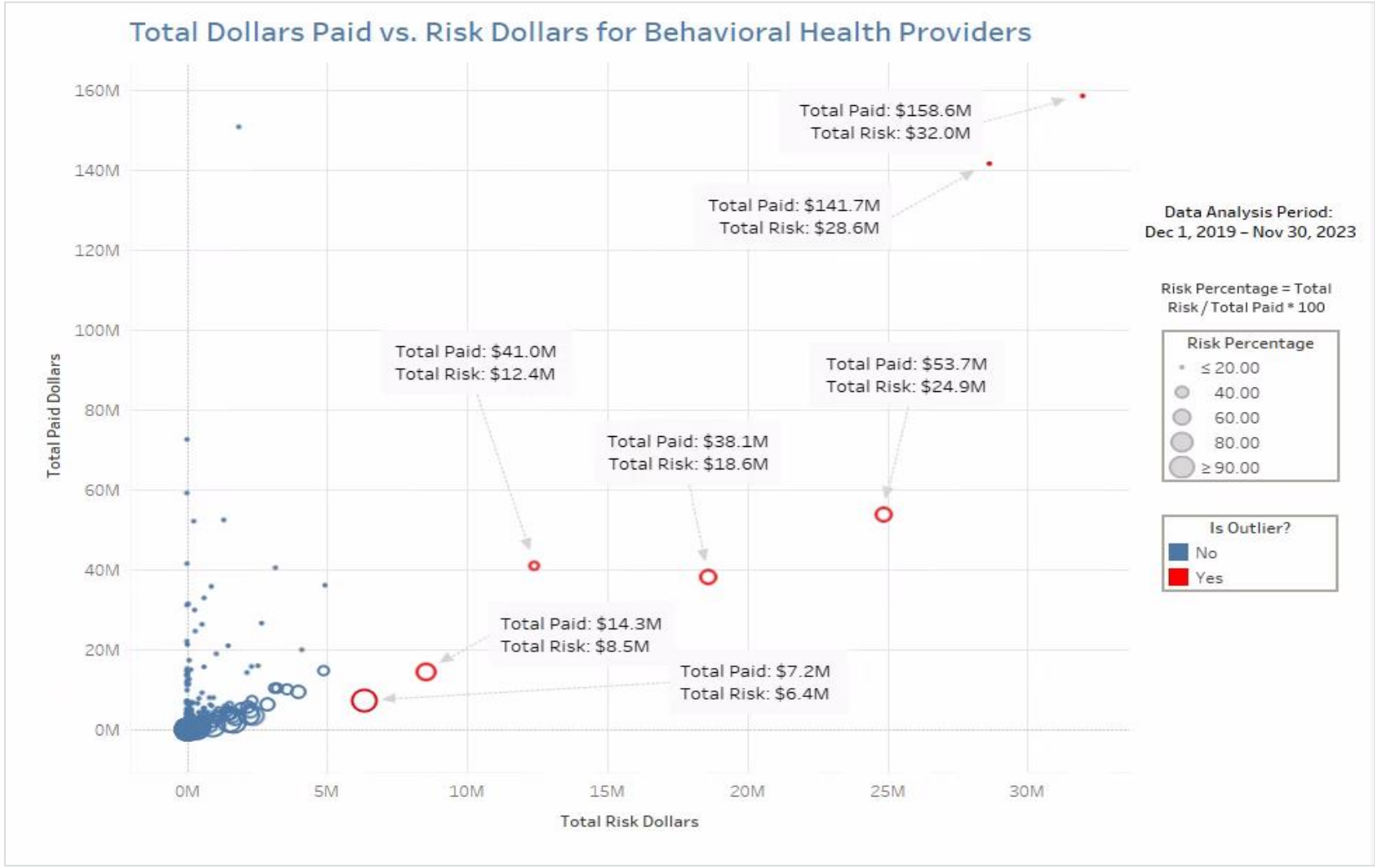
Administrative Enforcement

Statutory remedies

- Case closed (no wrongdoing).
- Education.
- Prepayment review of future claims.
- Recoupment of overpayment.
- Recovery of amount paid due to a violation plus additional penalties.
- Exclusion (for a term or permanent).

Fraud Detection

Data analytics



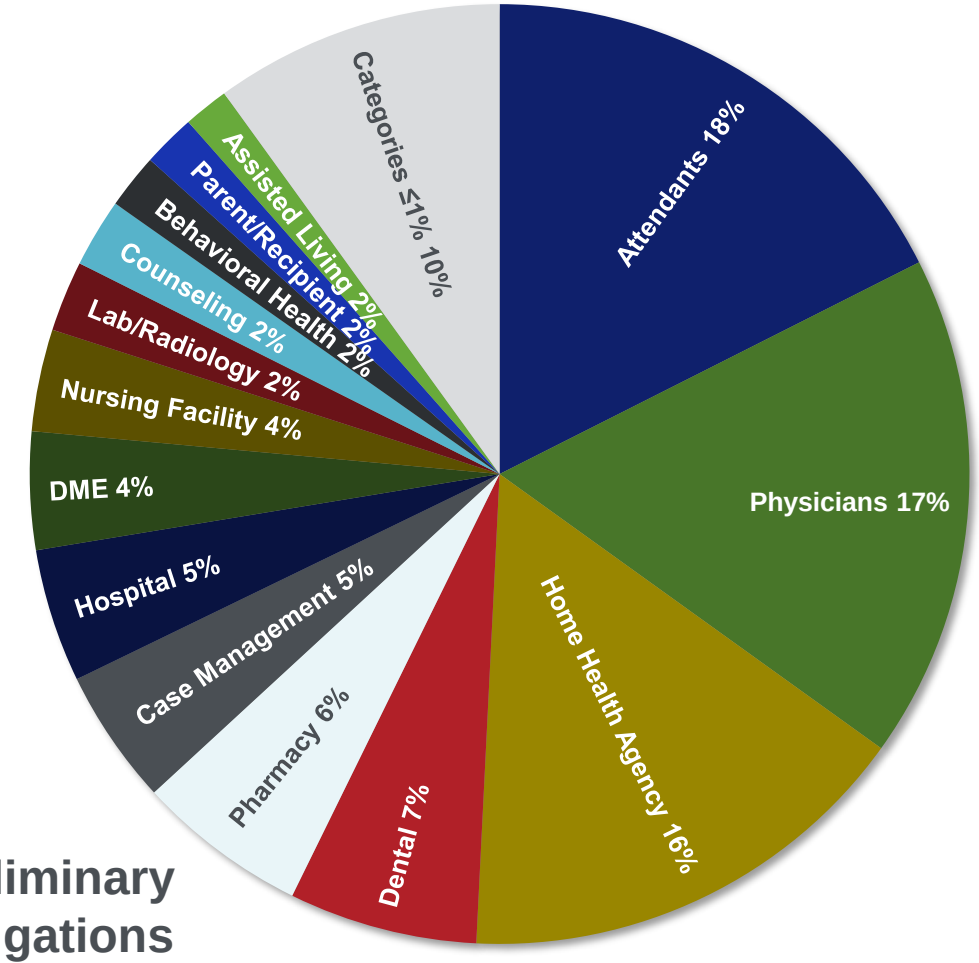
Common Fraud Schemes

Coding and Billing Errors

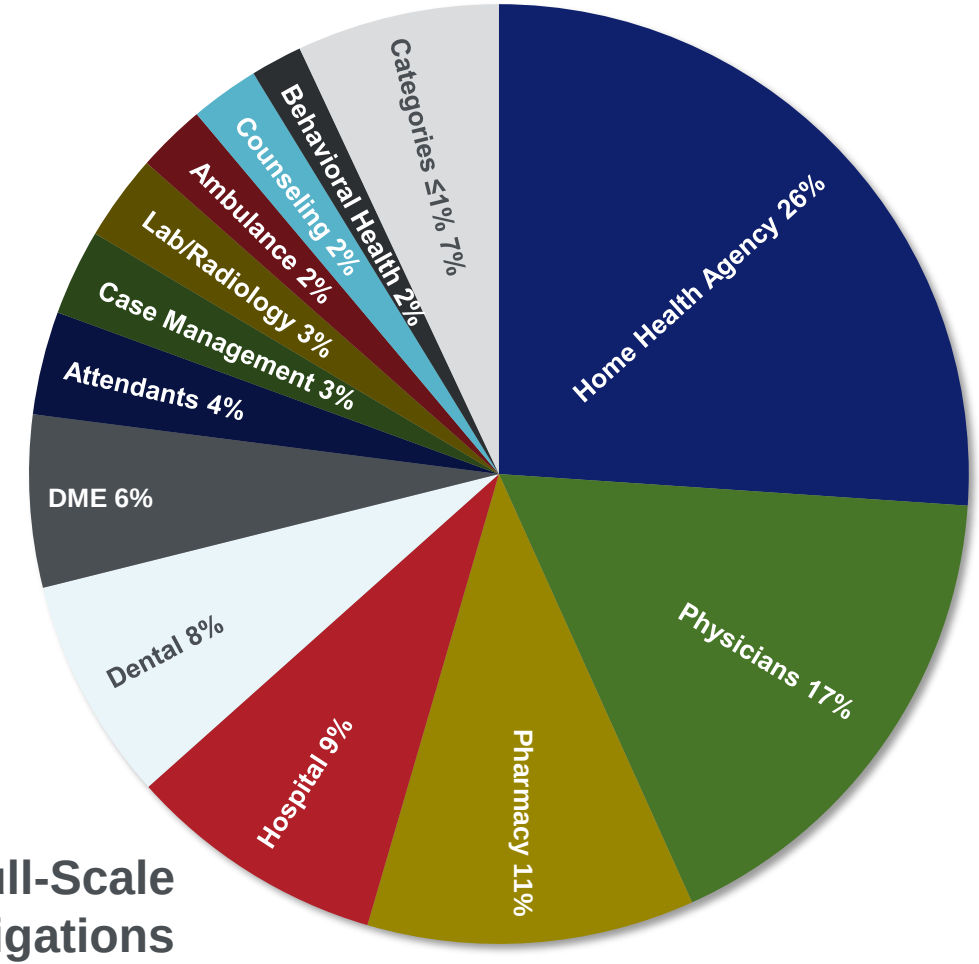
- **Upcoding** occurs when providers submit inaccurate CPT codes to receive higher reimbursements than the treatment or services actually provided and documented in the patient records.
- **Unbundling** refers to using multiple CPT codes for the individual parts of a procedure or service rather than a more appropriate code that encompasses all parts of the procedure or service.
- **Adding modifiers** to CPT codes to allow more than one procedure or service to be paid when it is not medically appropriate to do so.
- **Billing for procedures or services not covered** by Texas Medicaid or other Texas health care programs, such as age-restricted services billed for clients who don't meet the age requirement.
- **Failing to implement NCCI requirements** that either prohibit the payment of two procedures together or impose quantity limitations for certain procedures or services.

Investigations by Provider Type

FY 2024 through July



Preliminary Investigations



Full-Scale Investigations

Allegations by Provider Type

Provider type	Related allegations
Adult Day Care	Poor facility conditions. Quality of care.
Ambulance	Upcoding from basic to advanced life support. Documentation does not support the services billed.
Attendants	Attendant not providing services. Quality of care. Overlapping schedules of clients/attendant with multiple clients.
Case Management	Documentation does not support the services billed. Regulatory violations.
Dental	Billing for services not provided. Billing for a provider excluded from Medicaid. Solicitation. Billing for non-medically necessary services. Excessive services rendered on a single date of service. Upcoding. Quality of care. Provider not credentialed for the level of anesthesia provided. Lack of documentation/authorization.
Durable Medical Equipment	Billing for equipment not provided. Documentation does not support the services billed. Billing non-reimbursable procedure code(s).
Home Health Agency	Billing above the allowable amount. Upcoding for a higher level of care than rendered. Billing for services not rendered. Billing from a provider excluded from Medicaid

Allegations by Provider Type

Provider type	Related allegations
Hospital	Investigations into double billing in emergency room departments. Billing from a provider excluded from Medicaid.
Lab-Radiology	COVID-19 related scheme. Documentation does not support the services billed. Medically unnecessary genetic tests.
Nursing Facility	Quality of care. Upcoding RUG (Resource Utilization Group) scores. Forging documentation.
Pharmacy	Billing for services not rendered. COVID-19 related scheme. Billing for name brand dungs when dispensing generics.
Physician (Individual, Group or Clinic)	Billing for unnecessary services. Duplicate billing. Documentation does not support the services billed. Upcoding office visits or procedures. Quality of care; Billing for services not rendered. Billing a code that is not payable in Medicaid. Billing for a provider excluded from Medicaid. Including the wrong modifier or not indicating the modifier.
Therapy-Counseling	Billing for services not rendered. Documentation does not support the services billed. Failure to produce requested records.

Upcoding

OIG recoups almost $1.5 million in third-quarter UA-modifier cases

- **Provider type:** Home health agencies
- **No. of cases:** 4
- **Violation:** Agencies overbilled Medicaid by using the UA modifier, which provides increased reimbursements for tracheostomy or ventilator-dependent patients. However, the clients did not have a medical diagnosis that required a ventilator or indicated a tracheostomy.
- **Resolved:** FY 2024, Quarter 3
- **Total recovery amount:** **$1,496,585**

Double-Billing

OIG settles $1.8 million in emergency department billing cases

- **Provider type:** Hospitals
- **No. of cases:** 4
- **Violation:** Improperly claimed reimbursement for injections and infusions, which are already included in the E/M rate; billed for critical care, which is only allowed for physicians; double-billed E/M codes for the same patient on the same day; claimed reimbursement for mutually exclusive observation services and emergency room services.
- **Resolved:** FY 2024, Quarter 3
- **Total recovery amount:** **$1,823,941**

Pharmacy Inventory Investigations

Fort Worth pharmacies billed for more medications than purchased settling for $1.9 million

- **Provider type:** Pharmacies
- **No. of cases:** 2
- **Violation:** Billed for more medication than purchased; dispensed a generic but billed for a name brand; billed for a more expensive national drug code than dispensed for the same medication.
- **Resolved:** FY 2024, Quarter 3
- **Total recovery amount:** **$1,922,526**

Coding Manipulation

OIG settles case with out-of-state independent laboratory provider

- **Provider type:** Laboratory
- **No. of cases:** 1
- **Violation:** Medicaid only allows three antigen tests per day per client. The laboratory used modifiers to bypass claims system safeguards and bill for more tests than permitted. This allowed the lab to bill for the same test multiple times or bill for one service as if it were multiple services.
- **Resolved:** FY 2024, Quarter 1
- **Total recovery amount:** **$799,226**

Results

FY 2024

$442,367,188 Recovered.

$189,841,789 Cost avoidance.

1,852 Provider investigations.

16,707 Client investigations.

368 Retailer investigations.

1,086 State Center and IA investigations.

272 Cases referred to MFCU.

76,086 Provider enrollment screenings.

Thank you!

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