Transforming Lives

Medicaid Fraud Reporting and Payment Suspension Policy and Practical Training

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Washington State Department of Social & Health Services
Transforming lives

Washington State Department of Social and Health Services

LTC Manual

https://www.dshs.wa.gov/altsa/aging-and-disability

Washington State Department of Social and Health Services — How may we help you?

Aging and Long-Term Support Administration

About ALTSA | Frequently Asked Questions | Find Local Services, Information and Resources | ProviderOne

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ALTSA

Long-Term Care Professionals & Providers

- Home & Community Services
  - Long Term Care Manual
  - Specialized Dementia Care Program in Assisted Living Facilities
  - HCS Management Bulletins
  - Long Term Care Home & Community Based Services Waivers
- Residential Care Services
- Office of Rates Management
- Training Information
- Nurse Delegation Program
- Nursing Assistant Program
- Nursing Services
- Area Agencies on Aging Contractors
- Background Checks

Long-Term Care Services & Information

Aging and Disability Services Long-Term Care Manual

Chapter	Title	Revised
Chapter 1	POLICY AND ADMINISTRATION	12/2014
Chapter 2	Case records	12/2014
Chapter 3	Assessment and Care Planning	02/2015
Chapter 4		
Chapter 5	CASE MANAGEMENT	12/2014
Chapter 6	ADULT PROTECTIVE SERVICES	08/2015
Chapter 7	CORE LTC Programs	12/2014
Chapter 7A	IN- HOME PROVIDER REQUIREMENTS	04/2008
Chapter 8	RESIDENTIAL SERVICES	07/2012
Chapter 9	HOSPITAL ASSESSMENT	07/2001
Chapter 10	Nursing Facility Case Management and Relocation	11/2014
Chapter 11		
Chapter 12	ADULT DAY SERVICES	02/2015
Chapter 13	NURSE DELEGATION	12/2014
Chapter 14	LEGAL SERVICES	01/2008
Chapter 15	LIMITED ENGLISH PROFICIENT PERSONS	07/2015

New!
Chapter 28

Help

Register to Vote

dshs.wa.gov | ADSA - LTC M... | Aging and ...

Services — How may we help you?

	ADULT DAY SERVICES	02/2015
	NURSE DELEGATION	12/2014
	LEGAL SERVICES	01/2008
	LIMITED ENGLISH PROFICIENT PERSONS	07/2015
	ASSISTIVE TECHNOLOGY	10/2010
	Family Caregiver Support Program	05/2015
	HOME DELIVERED NUTRITION	
	CONGREGATE NUTRITION	
	TRANSPORTATION	01/2015
	VOLUNTEER CHORE SERVICE	
	Managed Care	12/2014
	QUALITY ASSURANCE AND IMPROVEMENT	12/2014
Chapter 24	NURSING SERVICES	02/2012
Chapter 25	PRIVATE DUTY NURSING	12/2014
Chapter 26	Medicare/Medicaid Integration Project (MMIP)	Rescinded
Chapter 27	New Freedom (Limited areas: King and Pierce Counties)	10/2011
Chapter 28	Medicaid Fraud	09/2015
Chapter 29	Roads to Community Living/WA Roads	12/2014

Printer-friendly version

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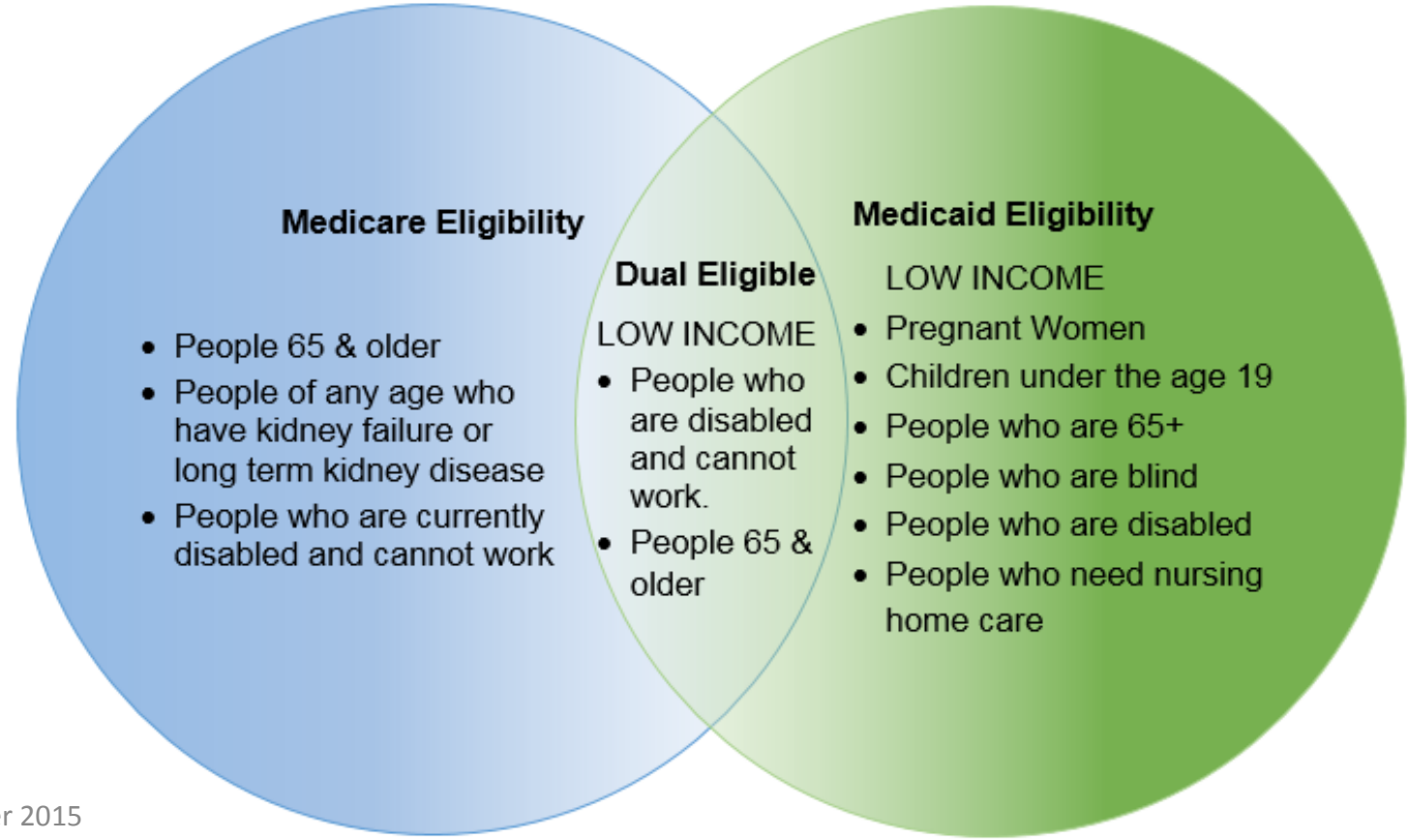
What is Medicaid?

Medicaid is health insurance for qualifying low-income and needy people.



Some providers of Medicaid services are:

- In Home Supports & Services
  - Individual Providers
  - Home Care Agencies
- Residential Services
  - Supported Living
  - Companion Homes
  - Adult Family Homes
  - Assisted Living Facilities
- Medical Providers
  - Physicians & Nurses
  - Hospitals
  - Clinics
  - Physical, Occupational & Speech Therapists
- Pharmacies
- Medical Equipment Suppliers

Some Medicaid covered services include hospital care, nursing home care, personal care services, residential services, behavior support and nursing. Washington Medicaid also includes managed care plans, hospice, mental health, dental services and vision care.

What is Fraud?

Fraud is theft by deception that results in an unauthorized benefit.

Medicaid Fraud is generally defined as the billing of the Medicaid program for services, drugs, or supplies that are intentionally or knowingly:

- *Unnecessary*
- *Not performed or are of a lower quality*
- *More costly than those actually performed*
- *Purportedly covered items, which were not actually covered*

42 CFR §455.2 Fraud Definition
RCW 9A.56.010 Deception definition
RCW 9A.56.020 Theft definition

When Fraud is Detected

- Improper payments must be paid back
- Providers/companies excluded from program
  - Can't bill Medicare, Medicaid or CHIP (any state)
- Fines are levied
- Law enforcement gets involved
- Arrests and convictions

Common types of fraud

- Billing for Services Not Performed
- Double Billing

- Kickbacks
- Cost Reports
- Upcoding or exaggerating the level of service performed

- Substitution of generic drugs

atg.wa.gov/common-types-medicaid-fraud

Preliminary Review Action Steps

1. Staff the case with supervisor before referring
2. Determine if the allegation of fraud is credible
3. Determine if it could be fraud

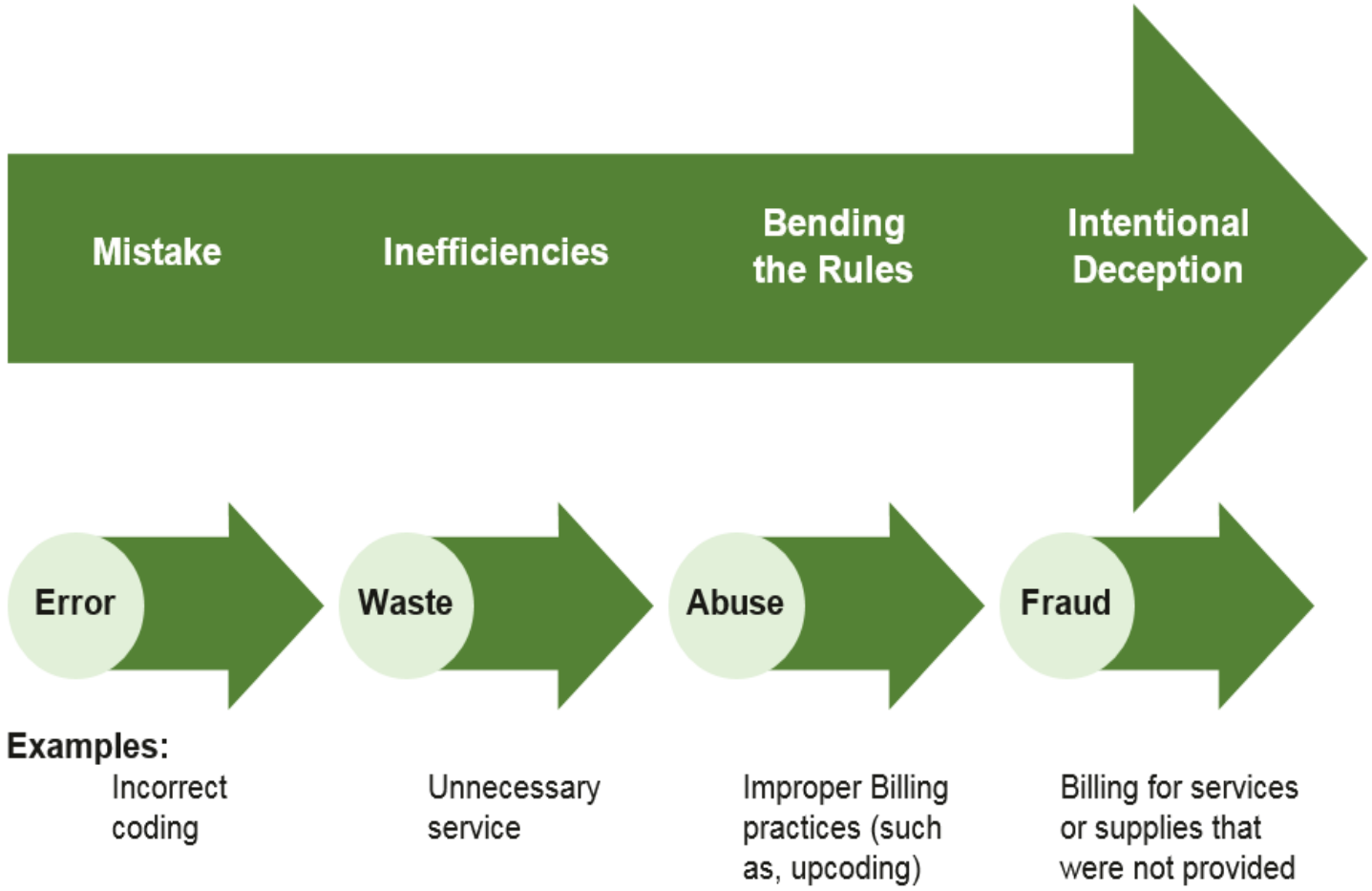
42 CFR §455.14 Preliminary investigation.

Allegations of Fraud

- Allegations are credible when there are signs, indicators or circumstances, which tend to show or indicate the allegation is probable ***and*** the reporting agency has reviewed all information, facts, and evidence carefully and acts judiciously on a case-by-case basis.
- Credible allegations are not mistakes, errors, misunderstandings or basic overpayments.

42 CFR §455.14 Preliminary investigation.

Fraud or Mistake?



Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf

Payment Suspension

Payment Suspension Pointers

- Payment suspension means that the payment authorization is terminated or end dated.
- Payment to the provider will be suspended unless a good cause exception exists, and the state chooses to keep paying a provider.
- Exceptions are limited.

42 CFR §455.23 Suspension of payments in cases of fraud.

Full or In Part

Payment suspension can be Full or In Part

- **Full Suspension** means that **all** payments to the provider, for all clients are ended.
  - Individual Provider, one client
- **In part** means that only **some** of the payments are suspended but other payments continue.
  - Agency Provider, multiple clients
  - Individual Provider with more than one client, allegation about only one client

Good Cause Exceptions

Payment Not Suspended due to Good Cause Exception

Allowable **Good Cause** reasons to either **(1) NOT suspend payments**, or **(2) NOT continue a payment suspension previously imposed** are:

- MFCU **requests** no payment suspension – could compromise or jeopardize an investigation
- **Other remedies** available
- Provider submits **evidence**; suspension is **ended**
- **Access to Care**
  - Provider is "sole source"
  - Serves large # of clients
- **Investigation ends**
- Not in the **best interests** of the program.

42 CFR §455.23 Suspension of payments in cases of fraud.

Payment Suspension In Part

Payment suspended only in part, acceptable Good Cause Exceptions:
❖ **Access to Care** ➢ Provider is "sole source" ➢ Serves large # of clients
❖ Provider submits evidence after suspension; **converted** to suspension in part
❖ Different **business area** of provider; no risk for fraud in other areas
❖ **Investigation ends**

42 CFR §455.23 Suspension of payments in cases of fraud.

Payment Suspension

Payment must be suspended if none of the good cause exceptions apply.

- Payment suspension can be initiated any time prior to submitting the provider fraud referral for investigation. Notice of the suspension must be sent to the provider within **five** (5) business days

Referral Process

What's New?
- Supporting Documentation

What's New?
- New Email Addresses

What's New?
- Staff with Supervisor

What's New?
- APS Referral Coordination

Submitting a Provider Fraud Referral

1. Prepare referral package
   - ❑Complete **12-210** Provider Fraud Referral Form,
   - ❑Gather all **supporting documentation**
2. Ensure appropriate action: Payment Suspension or Good Cause Exception is taken and documented
3. Ensure Notices to client and provider are sent

§455.23 Suspension of payments in cases of fraud.

Submitting a Provider Fraud Referral

4. Send complete referral form and all supporting information to either ProviderFraudDDA@dshs.wa.gov or ProviderFraudHCS@dshs.wa.gov
   - Field staff must use the centralized reporting system, which ensures compliance with federal regulation.

*The public may report Medicaid fraud directly to MFCU by calling (360) 586-8888 or by completing the online complaint form.

42 CFR §455.17 Reporting requirements.

Client Notification

- Each client served by the provider subject to payment suspension must receive a Planned Action Notice for choice of provider.
- Ten day notice is not required if there is a risk to the client's health or safety.
- PAN Authority is based on the applicable CFR and WAC references:
  - 42 CFR §455.23 Suspension of Payments in cases of Fraud
  - WAC 388-71-0540 When will the department, AAA, or department designee deny payment for services of an individual provider or home care agency long-term care worker?
  - WAC 388-71-0546 When may the department, AAA, or department designee reject your choice of an individual provider?

Provider Notification

- Providers must be notified within five days of payment suspension.
- The appropriate notice should be sent to the provider based on provider type, according to current practice & policy
  - Individual Provider
  - Agency provider

Who Investigates Fraud?

The Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) is responsible for both criminal and civil investigation and prosecution of health care provider fraud committed against the State's Medicaid program.

§455.16 Resolution of full investigation

RCW Chapter 74.66 Medicaid False Claims Act

Resolution

Investigations can take months or years to resolve.

- Headquarters receives updates on open cases monthly.
- MFCU notifies headquarters when cases are not accepted, closed or prosecuted. This information will be passed on to the referring case manager.
- When a referral is declined by MFCU and payment was suspended, payment suspension can be discontinued unless there is another issue:
  - APS referral
  - Other failure to comply with contract requirements
  - Character Competence & Suitability review before resuming payment

Full Investigation

Per federal regulation, a full investigation by MFCU continues until:

- Appropriate **legal action** is initiated
- The case is **closed or dropped** because of insufficient evidence
- The matter is **resolved** between the agency and the provider or beneficiary. This resolution may include but is not limited to:
  - A warning letter is sent to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;
  - Suspending or terminating the provider from participation in the Medicaid program;
  - Seeking recovery of payments made to the provider; or
  - Imposing other sanctions provided under the State plan.

§455.15 Full investigation

§455.16 Resolution of full investigation

Cooperation with MFCU

MFCU investigators may contact Field Staff for more information or documentation.

- Cooperate as fully as possible
- Provide additional documentation as requested
- Staff any contacts from MFCU with your supervisor

§455.16 Resolution of full investigation

§455.21 Cooperation with State Medicaid fraud control units

After the Referral

Follow Up

- HQ staff will monitor, track, and report on the follow-up provided by fraud investigators
- Headquarters will communicate with the region regarding investigation status including referrals declined/screened out and final outcomes.
- Any additional information or documentation for the investigation should be sent via email

Scam

Theft

Deception

Medicaid

Fraud

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Questions or Comments?

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