DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	MEDICAID FRAUD REPORTING AND PAYMENT SUSPENSION	11.03

Authority:		
	42 C.F.R. 455.23	*Suspension of payments in cases of fraud*
	42 C.F.R. 455, Subpart A	*Medicaid Agency Fraud Detection and Investigation Program*
	Chapter 9A.56 RCW	*Theft and Robbery*
	Chapter 74.66 RCW	*Medicaid Fraud False Claims Act*
	WAC 388-825-375	*When will the department deny payment for services?*
	WAC 388-115-05415	*When will the department deny payment to the CDE?*
	WAC 388-71-05415	*When will the department deny payment to the home care agency?*

BACKGROUND

Federal regulation requires the Department of Social and Health Services (DSHS) to have methods and criteria to identify suspected fraud cases, procedures regarding investigation of these cases, and processes for referring suspected fraud cases to law enforcement officials. The uniform reporting system brought DSHS into compliance with the reporting requirements of 42 C.F.R. 455.17.

PURPOSE

This policy establishes uniform reporting requirements and payment suspension procedures for DDA staff regarding incidents of suspected Medicaid fraud.

SCOPE

This policy applies to all DDA staff.

DEFINITIONS

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. (This definition is specific to 42 C.F.R. 455.2 and this DDA policy, and not as it applies to DDA Policy 5.13, *Protection from Abuse: Mandatory Reporting*.)

Credible allegation of fraud is an allegation that has been verified by DDA through a preliminary review of available information. Allegations are considered credible when there are signs, indicators, or circumstances, which tend to show or indicate that the allegation is probable.

DSHS Operations Review and Consultation (ORC) /Enterprise Risk Management Office (ERMO), is the principle point of contact with the State Auditor's Office for all DSHS reports of loss or illegal activity.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Full Investigation means the investigation conducted by the Medicaid Fraud Control Division after the state agency making the referral has conducted a preliminary review.

Good cause are conditions outlined in 42 C.F.R. 455.23 and below in this policy which permits the State Medicaid agency to not suspend payment or to only suspend a part of a payment.

Law Enforcement Exception (LEE) Authority means an agency or billing provider must not inform any people, entities, or their associates, who are subject to an MFCD investigation of fraud. An LEE allows an agency to continue issuing provider payments during an investigation in order to protect the integrity of the investigation and the safety of the agents involved.

Preliminary review is a careful and judicious review of allegations, facts, and evidence on a case-by-case basis, and that reasonably shows an incident of fraud or abuse may have occurred in the Medicaid program. Under 42 C.F.R. 455.14, this is called a preliminary investigation.

Washington State Medicaid Fraud Control Department (MFCD) is part of the Attorney General's office, conducts criminal and civil investigation and prosecutes healthcare provider fraud and abuse committed against the state of Washington's Medicaid program. Preliminary reviews of allegations of fraud or abuse that are found to be credible are referred to MFCD through a centralized reporting system at DDA HQ, for full investigation.

Waste is defined as any activity that uses resources but creates no value. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, or excess administrative costs.

POLICY

A. When a complaint alleging Medicaid fraud is received by the Department, federal rules require that a preliminary review be conducted to determine if there is sufficient basis to warrant a full investigation. After a preliminary review, DDA HQ refers credible allegations of fraud to the Medicaid Fraud Control Division (MFCD) for a full investigation. A DDA HQ designee sends concurrent notification of these referrals to DSHS Operations Review and Consultation (ORC) Enterprise Risk Management Office (ERMO).

1. Field staff, in consultation with their supervisor and Regional Payment Specialist, must begin a preliminary review by:

   a. Collecting and reviewing all available information;
   b. Determining if the allegation of fraud, waste, or abuse is credible; and
   c. Determining if a loss to the Medicaid program has occured.

2. If the preliminary review at the field level indicates the allegation is credible and there is a loss to the Medicaid program, field staff will complete the form DSHS 12-210, *Medicaid Provider Fraud Referral* (This link is available on the DSHS DDA intranet website only) and electronically submit all information compiled in the preliminary review to the Regional Payment Specialist. After a detailed review by the region, the Payment Specialist will forward the complete referral packet to DDA HQ.

3. DDA HQ will continue the preliminary review by reviewing the referral form and packet. Referrals that are credible and indicate a loss to the Medicaid program due to fraud, waste, or abuse will be referred to MFCD and ORC or ERMO.

4. Cases that are accepted by MFCD for investigation will be assigned to a MFCD Investigator. An investigation will continue until legal action is initiated, the case is closed or screened out because of insufficient evidence to support the allegations, or MFCD determines that the matter can best be resolved through other means as appropriate.

5. If an identified overpayment is found, wait until MFCD has finished their investigation before processing the overpayment. Once the investigation is complete, HQ notifies the responsible DDA staff, who must proceed with the overpayment according to DDA Policy 11.06, *Client and Provider Overpayments*.

6. DDA staff will cooperate with the MFCD investigatory and prosecutorial activities. This includes providing access to records or agency information as requested. DSHS and its contractors will also cooperate with the Health Care Authority with regard to the prevention and detection of fraud, waste, and abuse as outlined in the Cooperative Agreement between DSHS and HCA, and by extension through the Memorandum of Understanding between MFCD and HCA.

7. If a MFCD investigator contacts a DDA employee, the employee must immediately inform the Regional Payment Specialist who must notify the DDA HQ fraud liaison and Payment Unit Supervisor.

B. In accordance with the Affordable Care Act (ACA) and 42 CFR 455.23, the State of Washington must ensure federal funding is not provided to individuals or entities when there is a pending investigation of a credible allegation of fraud unless MFCD issues a law enforcement exception.

1. If MFCD ends the law enforcement exception and is continuing the investigation, DDA may continue authorizing provider payments if DDA determines that good cause exists.

2. DDA must suspend payments to a provider when there is a credible allegation of fraud and good cause does not exist to suspend payment. Terminating or end dating the provider's payment authorization is the equivalent of a payment suspension.

3. If DDA does not suspended payment or suspends only in part, the HQ liaison must document the justification each month payment is suspended to fulfill federal rules.

C. When client fraud is suspected, HQ will make a report to the Office of Fraud and Accountability (OFA) according to the procedures outline below.

PROCEDURES

A. Preliminary Review and Referral for Full Investigation

1. A preliminary review will be conducted when there is suspected provider fraud, waste, or abuse resulting in a loss to the Medicaid program.

a. The case manager must:

i. Discuss allegations of fraud with their supervisor;

ii. Follow-up with a regional payment specialist, who can offer support such as policy interpretation and preliminary documentation review; and

iii. Notify the field service administrator or the deputy regional administrator before sending the fraud referral to DDA HQ.

b. The preliminary review by the region into the circumstances of the allegation will consist of a review of all relevant supporting information and documentation to determine if the allegation is credible and there was a loss to the Medicaid program.

c. If the allegation is credible, the reporting staff completes form DSHS 12-210 (*Medicaid Provider Fraud Referral*) and submits it to their Regional Payment Specialist along with supporting information. Do not include name(s) of individuals making the allegation on this form. A complete referral packet will include as much information to support the allegation as is available. The referral packet should include:

i. The *Medicaid Provider Fraud Referral* form DSHS 12-210.

ii. Documented information that supports the allegation gathered during the preliminary review such as:

A) Timesheets or other record of services;

B) Service Episode Records (SER) documenting conversations with the provider, client, or both about service delivery or contract requirements;

C) Service summary;

D) Signed provider contract and current contract status; and

E) Current authorizations and their status.

d. Regional Payment Specialists will review the form and supporting information for completeness before submitting to DDA HQ.

e. After a referral has been determined to be complete. The Regional Payment Specialist will send the referral form and supporting information to ProviderFraudDDA@dshs.wa.gov.

f. DDA HQ reviews all referrals for completeness and compliance with federal and state regulations.

i. DDA HQ will forward credible allegations to MFCD for full investigation.

ii. DDA HQ will record credible referrals that are passed on to MFCD for full investigation in the centralized tracking database maintained jointly by Home and Community Services (HCS) and DDA.

iii. DDA HQ will monitor, track, and report on follow-up information provided by MFCD's fraud investigators.

iv. DDA HQ will communicate with the Regional Payment Specialist regarding all referrals made to the shared reporting database, including information on when referrals were sent to MFCD for full investigation, and status updates for ongoing investigations and changes in status.

2. When MFCD investigators contact DDA staff in relation to an investigation, the DDA staff will inform their Regional Payment Specialist, who will inform DDA HQ. The information provided by the DDA staff will include:

a. The name of the DDA staff contacted,

b. The name of the MFCD investigator and contact information,

c. Date and time of the contact,

d. A brief description of the contact with the investigator,

e. The name of the agency or individual under investigation,

f. Information regarding the current status of the investigation or status changes, and

g. Information on any new information or Incident Reports generated for the situation under investigation.

B. Payment Suspension and Notification

1. If MFCD accepts the referral, law enforcement exception (LEE) will automatically apply, and payment will not be suspended. In accordance with 42 CFR 455.23, MFCD will notify DDA HQ liaison of LEE within five days of DDA sending the referral.

Note: To protect the integrity of the investigation and the safety of the agents involved, DDA staff must not discuss the investigation with any person outside of DSHS or MFCD.

2. If the LEE ends and the investigation remains open, the DDA HQ liaison, field staff, and the billing provider as appropriate, must determine whether good cause exists, and payment should continue. Good causes exists if one or more of the following apply:

a. Payment suspension is not in the best interests of the Medicaid program.

b. Client access to care would be jeopardized by a payment suspension because:

i. The provider is the sole source of essential specialized services in a community; or

ii. The provider serves a large number of clients within a federally designated medically underserved area.

c. MFCD closes the case or it is screened out because of insufficient evidence to support the allegations, or determines that the matter can best be resolved through other appropriate means.

d. DDA may end a previously imposed suspension at the discretion of regional and HQ leadership if DDA receives sufficient reason in writing from the subject of the investigation.

e. Other available remedies implemented by the state more effectively or quickly protect Medicaid funds.

3. Payment suspension should not be initiated before the referral is sent from DDA HQ to MFCD referral for full investigation.

4. If MFCD removes the LEE and there is no good cause, payment suspension must be initiated within five days.

~~5.~~ Payment must be reinstated unless there are exceptions that require the department to not resume payment, including but not limited to:

6. Partial payment suspension may be appropriate when a provider has more than one client or the provider has more than one client but the credible allegation of fraud is regarding only one client, and there are no issues with the remaining client(s). The Department may choose to partially suspend payment only if one or more of the following are applicable:

a. Client access to care would be jeopardized by full payment suspension because of either of the following:

i. An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or

ii. The individual or entity serves a large number of beneficiaries within a federally designated medically underserved area.

b. The Department determines, based upon the submission of written evidence by the individual or entity that is the subject of a payment suspension, that full payment suspension should be imposed only partially.

c. The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; or

d. The state determines and documents in writing that a partial payment suspension would effectively ensure that potentially fraudulent claims were not continuing to be paid.

7. Notification of payment suspension will occur as follows:

   a. Payment suspension notifications will be sent if the agency or DDA contracted provider as a whole is suspected of committing the fraud. If some servicing providers employed the agency or DDA contracted provider are suspected of committing fraud, but the agency, itself, is not suspected, the agency will be expected to take internal action to prevent further fraud.

   b. If an entire agency receives suspension, each client served by the provider must receive a Planned Action Notice regarding denial of provider of choice. Ten-day notice is not required if there is a risk to the client's health or safety.

   c. Notice to the provider regarding the termination of the payment must be sent within five days from the date the authorization is terminated, in accordance with the federal requirement at 42 CFR §455.23(b).

      Note: If the provider is not an Individual Provider, coordinate provider notification with DDA HQ.

8. Documentation of payment suspension and notification, or good cause exception not to suspend payment, will be made as follows:

   a. For a provider with one or only a few clients, such as an Individual Provider, the case manager will document in the client's SER in CARE. The documentation should indicate that a referral was made and when, a brief summary of the circumstances, and if applicable, Law Enforcement Exception and the specific Good Cause Exception. For multi-client providers a note in their contract folder can also be made at DDA staff discretion.

   b. DDA HQ will document payment suspension or Good Cause Exception in the Fraud-Reporting Database.

C. Client Fraud Reporting

1. When client fraud is suspected, case managers will make a report to the Office of Fraud and Accountability (OFA).

a. Case managers will staff the alleged allegation with a supervisor and possibly others per regional practice.

b. DDA staff will report suspected client fraud using the FRED (Fraud Early Detection) process in Barcode. Steps on how to access FRED can be found on the DDA Medicaid Fraud Reporting page.

c. DDA staff without access to Barcode will complete the DSHS 12-209, *Client Fraud Report* form, and submit the form to ProviderFraudDDA@dshs.wa.gov. (This link is available on the DSHS DDA intranet website only). DDA HQ staff will submit reports made on DSHS 12-209 to OFA using the FRED database in Barcode.

2. In order to report suspected client fraud using this form, the client must have an ADSA ID number. If a client does not have an ADSA ID, the client fraud activity should be referred to the client's financial worker, who can submit the referral through the FRED process in Barcode.

EXCEPTIONS

Exception to Rule (ETR) for Medicaid fraud reporting or payment suspension must adhere to the requirements outlined in CFR or RCW. The written prior approval of the Assistant Secretary or Deputy Assistant Secretary is required for any exception to Chapter 388-825 WAC or DDA Policy.

SUPERSESSION

DDA Policy 11.03, *Medicaid Fraud Reporting and Payment Suspension*
Issued April 15, 2017

Approved: _____ Date: November 15, 2024
Deputy Assistant Secretary
Developmental Disabilities Administration