

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: MEDICAID FRAUD REPORTING POLICY 11.03
AND PAYMENT SUSPENSION

Authority: [42 CFR §455.2](#) *Definitions*
[42 CFR §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 of an individual or home care agency providing respite care, attendant care, or personal care services?*
[WAC 388-825-380](#) *When may the department reject the client's choice of an individual respite care, attendant care or personal care provider?*
[WAC 388-825-385](#) *When may the department terminate an individual respite care, attendant care, or personal care provider's contract?*

BACKGROUND

Home and Community Services (HCS) Division's Management Bulletin (MB) [H13-011](#) established a centralized system for reporting and tracking of suspected client or provider Medicaid fraud. 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 CFR §455.17.

This policy expands on the guidance for fraud reporting and payment suspension established in MB H13-011. This policy establishes direction to Developmental Disabilities Administration (DDA) staff on payment suspension, documentation requirements when payment is not suspended due to good cause, or is suspended only in part due to good cause.

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 DDA field 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 in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. (This definition is specific to 42 CFR §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.

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.

Medicaid Fraud Control Unit (MFCU) 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 MFCU through a centralized reporting system for full investigation.

Preliminary Review is a review of allegations, facts, and evidence that have been reviewed carefully and judiciously on a case-by-case basis and give DDA reason to believe that an incident of fraud or abuse has occurred in the Medicaid program.

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. While all fraud is waste, not all waste is fraud.

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. Credible allegations of fraud will be referred to MFCU for a full investigation.

1. Field staff will conduct a preliminary review of available information to determine if there is a credible allegation of fraud, waste, or abuse, which has resulted in a loss to the Medicaid program.
2. If the preliminary review at the field level indicates there has been a loss to the Medicaid program through fraud resulting from action that is not accidental or inadvertent, field staff will complete the [DSHS 12-210, Medicaid Provider Fraud Referral](#), form and forward the form and supporting documents to DDA Headquarters. Note: This link is available on the DSHS DDA intranet website only.
3. DDA Headquarters will review the referral as part of the preliminary review process. Referrals that are credible and indicate a loss to the Medicaid program due to fraud, waste, or abuse will be referred to MFCU for a full investigation.
4. Cases that are accepted by MFCU for investigation will be assigned to a MFCU Investigator.

An investigation will continue until legal action is initiated, the case is closed or dropped because of insufficient evidence to support the allegations, or MFCU determines that the matter can best be resolved through other means as appropriate.

5. DDA staff will cooperate with the MFCU 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 MFCU and HCA.
- 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.
1. Payments to a provider must be suspended when there is a credible allegation of fraud, unless good cause exists not to suspend payment. Terminating or end dating the provider's payment authorization is the equivalent of a payment suspension.
 2. If the payment is not suspended or suspended only in part, federal rules require that a good cause exception must be documented.

PROCEDURES

- A. A preliminary review will be conducted when there is suspected provider fraud, waste, or abuse resulting in a loss to the Medicaid program.
1. Case managers will staff allegations of fraud with their supervisor.
 2. The region may include headquarters program staff in the regional preliminary review process at their discretion.
 3. 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.
- B. A referral for full investigation will be initiated when allegations of fraud, waste, or abuse are found to be credible through a preliminary review. The referral for full investigation will include:
1. The *Medicaid Provider Fraud Referral* form ([DSHS 12-210](#)). (This link is available on the DSHS DDA intranet website only.)
 2. Supporting documentation and information that support the credibility of the allegation gathered during the preliminary review. Examples include:
 - a. Service Episode Record (SER) notes documenting conversations with the provider and/or client about service delivery or contract requirements;
 - b. Timesheets or other record of services;
 - c. Care plan; and
 - d. Provider contract.
 3. The referring DDA staff will send the referral along with electronic versions of supporting documentation to ProviderFraudDDA@dshs.wa.gov.

Note: DDA staff are not to send referrals directly to MFCU.
 4. Headquarters staff monitors the centralized referral address.
 - a. Referrals will be reviewed for completeness and compliance with federal and state regulations.

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- b. DDA Headquarters staff will record credible referrals made for full investigation in the centralized tracking database maintained jointly by HCS and DDA.
 - c. DDA Headquarters program staff will forward the complete referral package along with any supporting documentation to the appropriate investigating entity, MFCU and/or the DSHS Office of Fraud and Accountability (OFA), as appropriate.
 - d. DDA Headquarters program staff will monitor, track, and report on follow-up provided by the fraud investigators.
 - e. DDA Headquarters program staff will notify the referring staff when the provider fraud referral is submitted to MFCU.
 - f. DDA Headquarters will communicate with the region regarding all referrals made to the shared reporting database including information on when referrals are sent to MFCU for full investigation and status updates on ongoing investigations and changes in investigation status.

C. Payment Suspension and Good Cause Exception Practice and Documentation

1. The Department may choose to not suspend payment or to discontinue a previously imposed payment suspension only if one or more of the following are applicable:
 - a. MFCU specifically requests that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
 - b. Other available remedies implemented by the state more effectively or quickly protect Medicaid funds.
 - c. Based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, the suspension should be removed.
 - d. Client access to care would be jeopardized by a payment suspension because of either of the following:
 - 1) The individual or entity is the sole source of essential specialized services in a community; or

- 2) The individual or entity serves a large number of clients within a federally designated medically underserved area.
 - e. MFCU declines to certify that the matter continues to be under investigation.
 - f. Payment suspension is not in the best interests of the Medicaid program.
 2. Partial payment suspension may be applicable when a provider has more than one client, 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. Beneficiary access to items or services would be jeopardized by full payment suspension because of either of the following:
 - 1) An individual or entity is the sole community physician or the sole source of essential specialized services in a community; or
 - 2) 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.
 3. Payment must be suspended if none of the good cause exceptions is applicable.
 - a. Payment suspension should not be initiated prior to the referral for full investigation and no later than five (5) days following the referral for full investigation.
 - b. When a referral is declined by MFCU and payment was suspended, payment suspension must be discontinued unless there are other applicable reasons to continue the suspension.

4. Notification of payment suspension must occur as follows:
 - a. Each client served by the provider must receive a Planned Action Notice regarding denial of provider of choice. Ten (10) day notice is not required if there is a risk to the client's health or safety.
 - b. Notice to the provider regarding the termination of the payment must be sent within five (5) days from the date the authorization is terminated, in accordance with the federal requirement at 42 CFR §455.23(b). If the provider is an Individual Provider, notification will be made using the [DSHS 16-198, Individual Provider Notification](#) form. This link is available on the DSHS DDA intranet website only. If the provider is not an Individual Provider, coordinate provider notification with DDA Headquarters.
 5. 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, the specific Good Cause Exception. A note in the provider's contract folder can also be made at field staff discretion for larger providers.
 - b. Headquarters will document payment suspension or good cause exception in the fraud-reporting database.
- D. When client fraud is suspected, case managers will make a report to the Office of Fraud and Accountability (OFA).
1. Case managers will staff the alleged allegation with a supervisor and/or others per regional practice,
 2. DDA staff with access to Barcode will report suspected client fraud using the Fraud Early Detection (FRED) process in Barcode.

Steps on how to access FRED can be found on the DDA SSPS SharePoint page.
 3. 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.

Headquarters staff will forward suspected client fraud reported to the fraud email address to OFA.

Note: 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 cannot exempt requirements in CFR or RCW. The prior written approval of the Assistant Secretary or Deputy Assistant Secretary is required for any exception to Chapter 388-825 WAC or DDA Policy.

SUPERSESSION

None.

Approved: /s/ Donald Clintsman
Deputy Assistant Secretary
Developmental Disabilities Administration

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