

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Effective Date: 01/01/11
Section: General Policy	Section: 7.04	
Subject: Fraud and Abuse	Pages: 4 Cross Reference: DOM Addresses and Telephone Numbers 1.05	

Title XIX of the Social Security Act, the implementing federal regulations 42 CFR Part 455, and the Mississippi Code of 1972, Title 43 Chapter 13 as amended, set forth the state Medicaid agency's requirements for control of fraud and abuse in the Medicaid program. The Division of Medicaid (DOM) employs detailed methods and procedures to prevent, detect, investigate, report, identify, and collect all improper payments, and impose administrative measures for the control of fraud, abuse, and over utilization practices by providers and beneficiaries. The Mississippi Code of 1972, Title 43 Chapter 13 as amended, describes the penalties related to fraud in the Medical Assistance Program. Suspected fraud/abuse regarding a provider or beneficiary should be addressed to the DOM Bureau of Program Integrity. When a provider identifies any overpayments made by Medicaid caused by billing errors, system errors, human error, etc., he/she should notify the DOM Bureau of Program Integrity in writing within 30 days of the discovery. Refer to Provider Policy manual section 1.05 for DOM address and telephone contact information.

Self Disclosure:

The Division of Medicaid encourages providers to be active participants in ensuring the financial integrity of our healthcare programs. Providers are urged to self-audit in an effort to identify claim errors and overpayments. Providers have an ethical and legal duty to promptly return inappropriate payments they have received from the Medicaid Program. The DOM will accept reimbursement for inappropriate payments without penalty in the event that such inappropriate payments are disclosed voluntarily and in good faith, and that the acts that led to the inappropriate payments were not the result of fraudulent or abusive conduct. Upon identifying claims errors or overpayment, providers must alert DOM's Bureau of Program Integrity and work toward a resolution or refund. Once a provider has identified claims that are potential overpayments, the Medicaid Provider Self Disclosure Form detailing the potential overpayments should be forwarded to the Program Integrity Bureau within 30 days of the discovery. Any self disclosure submitted to DOM for consideration must include the following information:

- a. Name and address of the affected provider;
- b. If the provider is an entity owned, controlled, or otherwise part of a system or network, include a description or diagram of the pertinent business/legal relationships, the names and addresses of any related entities, and affected corporate divisions, departments, or branches. The description should include the name and address of the disclosing entity's designated representative.
- c. Provider Identification Number(s) associated with claims;
- d. Tax Identification number(s);
- e. Payee Identification number(s);
- f. Submit affected claims in Excel or Access and should include the following information beneficiary name, claim TCN, procedure code, service from/to date, billed amount, paid amount, paid date, refund amount. (Providers are encouraged to contact the Program Integrity Bureau prior to submitting reports to insure acceptance of information being submitted)
- g. A report that includes a full description of the matter being disclosed, the person who identified the overpayment and the manner in which the individual discovered it;
- h. The self disclosure should include a detailed account of the provider's investigation of the overpayment.
- i. A statement disclosing whether the provider is under investigation by any government agency or contractor;
- j. A statement detailing the provider's theory regarding the cause of the violation;
- k. A certification that the information submitted to the DOM is based upon a good faith effort to disclose a billing inaccuracy and is true and correct and;
- l. The methodology used in determining the amount of the overpayment (if overpayment amount was determined using a sampling method additional detailed information may be required).

Documentation should be sent to the address listed in Section 1.05 of this manual.

The Bureau of Program Integrity reserves the right to verify the financial impact of the disclosed matter. Accordingly, the DOM expects to receive documents and information from the entity that relate to the disclosed matter without the need to resort to compulsory methods. Matters uncovered during the verification process which are outside the scope of the self disclosure may be treated as new matters subject to further investigation.

To the extent that payments can be returned through the claims payment adjustment process, the claims adjustment process will be followed. Otherwise, providers should send refund checks, made payable to The DOM at the address listed in Section 1.05 of this manual within 60 days of the overpayment discovery.

Please note that self disclosure will not absolve the provider of criminal culpability.

Corrective Action Plans:

In an effort to correct deficiencies noted during an investigation, the DOM can require the submission of a Corrective Action Plan. Corrective Action Plans must be specific and must, at a minimum, include provisions aimed toward correction of the deficiencies, indicate reasonable completion dates, fully describe the methodology used to accomplish complete and permanent corrective action, and describe methods for ensuring full compliance with the corrective action plan. The Corrective Action Plan shall be subject to review by the DOM to ensure compliance. Violation of the Corrective Action Plan, including failure to implement as directed, will subject the provider to further adverse actions and may be based upon both the initial investigation and the Corrective Action Plan.

Overpayments

When it is established through audit or investigation that an overpayment has been made to a provider, the DOM shall begin collection of any overpayment to a provider 60 days after issuance of the demand for repayment. The overpayment may be recovered by any legitimate methods which may include any of the following methods:

1. Lump sum payment by the provider.
2. Offset against current payments due to the provider.
3. A repayment agreement executed between the provider and DOM.
4. Any other method of recovery available to and deemed appropriate by the DOM.

An offset against current payments shall continue until one of the following occurs:

- a. The overpayment is recovered;
- b. The DOM enters into an agreement with the provider for repayment of overpayments.
- c. The DOM determines, as a result of hearing proceedings or review of information that there is no overpayment.

Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider.

Suspension of Payments

In section 6402(h) of the Affordable Care Act, the Congress amended section 1903(i)(2) of the Act to provide the Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including

items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State in accordance with these regulations, unless the State determines in accordance with these regulations that good cause exists not to suspend such payments.

Basis for suspending payments to Providers

The Division of Medicaid may suspend payments in whole or in part to a provider when there is a pending investigation of a credible allegation of fraud unless the state determines that good cause exists not to suspend such payments. Examples of good cause are the following:

- Specific requests by law enforcement that DOM not suspend (or continue to suspend) payment.
- DOM has determined that other available remedies exist that could effectively or quickly protect Medicaid funds than would implementing (or continuing) a payment suspension.
- DOM determines that a payment suspension is not in the best interests of the Medicaid program.
- DOM determines that a payment suspension would have an adverse effect on beneficiary access to necessary items or services.
- Law enforcement declines to cooperate in certifying that a matter continues to be under investigation.

DOM may suspend payments without first notifying the provider of its intention to suspend such payments as allowed under state and/or federal laws and regulations.

The Medicaid Fraud Control Unit (MFCU) can refer to the Division of Medicaid any provider against which there is pending an investigation of credible allegation of fraud for purposes of payment suspension. Referrals from MFCU must be in writing and include information adequate to enable the Division of Medicaid to identify the provider and a brief explanation forming the grounds for the payment suspension.

The Division of Medicaid shall make a formal, written suspected fraud referral to MFCU for each instance of a payment suspension as the result of a Division of Medicaid preliminary investigation of a credible allegation of fraud.

Notice of payment suspension to Providers

The Division of Medicaid must send notice of payment suspension to providers within five (5) days of taking such action. Exception to the five (5) day notice period occurs when the Division of Medicaid receives a written request by law enforcement to delay notification to a provider. Law enforcement can request up to a 90 day notification of delay.

The payment notice must set forth the general allegations as to the nature of the suspension of payments, but does not require disclosure of any specific information regarding the ongoing investigation. The notice must:

- State the payments are being suspended in accordance with 42 CFR Section 455.23.
- State that the suspension is for a temporary period and cite the circumstances under which the payment suspension will be terminated.
- Indicate, when appropriate, which type or types of Medicaid claims will be suspended.
- Inform the provider of the right to submit written evidence for consideration by the Division of Medicaid.

Duration of Suspension of Payments to Providers

All suspension of payments will be temporary and will not continue after:

- The Division of Medicaid or the prosecuting authorities determines that there is insufficient evidence of fraud.

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- Legal proceedings related to the provider's alleged fraud are completed.

Recovery Audit Contractors (RACs) Program

In accordance with Section 6411 of the Affordable Care Act the Division of Medicaid has established a program to comply with these requirements. The Division of Medicaid will contract with one or more Medicaid RACs for the purpose of identifying underpayments, overpayments and recouping overpayments under the State Plan and under any waiver of the State Plan with respect to all services. Payments to RAC contractors for the identification of overpayments will only be made from amounts recovered. Contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. This program may be adjusted pursuant to future regulation/guidance promulgated by CMS.

Through its procurement process the State will establish the following:

- a. Qualifications of Medicaid RACs;
- b. Required personnel;
- c. Contract duration;
- d. RAC responsibilities;
- e. Timeframes for completion of audits/recoveries;
- f. Audit look-back periods;
- g. Coordination with other contractors and law enforcement;
- h. Appeals process for RACs to follow;
- i. Contingency fee considerations;
- j. other terms and conditions as necessary.

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Subject: Fraud and Abuse	Pages: 4-4	
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- Audit look-back periods;
- Coordination with other contractors and law enforcement;
- Appeals process for RACs to follow;
- Contingency fee considerations;
- other terms and conditions as necessary.

Medicaid Provider Self Disclosure Form

Provider Name: _____ Provider Number: _____

Address: _____ City _____

State: _____ ZIP Code: _____

Related entities, affected corporate divisions, departments or branches:

Provider Identification Number(s) associated with claims: _____

Tax ID number(s): _____

Description of the matter being disclosed: _____

Person who identified the overpayment: _____

How it was discovered: _____

Summary of provider's review of the overpayment: _____

Is the provider under investigation by any government agency or contractor? Yes _____ No _____

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to DOM is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature _____ Date _____

Mail or fax form to: Division of Medicaid, Bureau of Program Integrity, Suite 1000, Walter Sillers building, 550 High Street, Jackson, MS 39201, (601) 576-4162, Fax (601) 576-4161