Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: MEDICAID FRAUD REPORTING AND PAYMENT SUSPENSION — POLICY 11.03

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

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 originally 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 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 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.

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 Unit after the state agency making the referral has conducted a preliminary review.

Good Cause are conditions outline in Title 42 §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.

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. Title 42 §455.14 calls this a preliminary investigation.

Washington State Medicaid Fraud Control Unit (MFCU) 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 MFCU through a centralized reporting system at DDA Central Office, 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. DDA Central Office will refer credible allegations of fraud after a preliminary review to Medicaid Fraud Control Unit (MFCU) for a full investigation. Concurrent notification of these referrals will be sent by DDA Central Office to DSHS Operations Review and Consultation (ORC) Enterprise Risk Management Office (ERMO).

1. Field staff will begin the preliminary review by collecting and reviewing all available information and will determine if the allegation of fraud, waste, or abuse is credible and also has resulted in a loss to the Medicaid program.

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 DSHS 12-210, *Medicaid Provider Fraud Referral* form (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 Central Office.

3. DDA Central Office 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 MFCU and ORC/ERMO.

4. Cases that are accepted by MFCU for investigation will be assigned to an MFCU 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 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.

6. When DDA staff are contacted by a MFCU investigator they will inform the Regional Payment Specialist who will notify DDA Central Office.

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 Good Cause exists not to suspend payment.

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 each month payment is suspended.

C. When client fraud is suspected, case managers 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. Case managers will staff allegations of fraud with their supervisor. The region may include Central Office program staff in the regional preliminary review process at their discretion.

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 the DSHS 12-210, *Medicaid Provider Fraud Referral* form 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:

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

2) 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, the 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 prior to submitting to DDA Central Office.

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 Central Office reviews all referrals for completeness and compliance with federal and state regulations.

1) DDA Central Office will forward credible allegations to MFCU for full investigation.

2) DDA Central Office will notify the DDA Incident Management Program Manager when the Medicaid Provider Fraud Referral form is submitted to MFCU. When the referral to MFCU is made, a concurrent loss report will be sent to ORC/ERMO by DDA Incident Management Program Manager detailing the credible allegation. The loss report will include:

a) The Operation Review and Consultation *Loss of Public Funds, Assets, or Illegal Activity Report* form (DSHS 17-169). (This link is available on the DSHS DDA intranet website only); and

b) Information that supports the credibility of the allegation gathered during the preliminary review.

3) DDA Central Office will record credible referrals that are passed on to MFCU for full investigation in the centralized tracking

database maintained jointly by Home and Community Services Division (HCS) and DDA.

4) DDA Central Office will monitor, track, and report on follow-up information provided by MFCU's fraud investigators.

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

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

a. The name of the DDA staff contacted,

b. The name of the MFCU 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. Payment will be suspended within five (5) days of the referral being sent by DDA Central Office to MFCU unless good cause exists not to suspend payment or good cause exists to only suspend payment in part. Payment suspension should **not** be initiated prior to the referral being sent from DDA Central Office to MFCU referral for full investigation.

2. After the referral is sent from DDA Central Office to MFCU payment suspension must be initiated within five (5) days.

3. DDA may choose to not suspend any payments or to discontinue a previously imposed payment suspension only if one or more of the following are applicable:

    a. MFCU requests that payment not be suspended because suspension of payment would compromise or jeopardize an investigation;

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

    c. A previously imposed suspension should be removed based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension;

    d. Client access to care would be jeopardized by a payment suspension due to 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 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 means as appropriate; or

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

4. When a referral is declined by MFCU and payment was suspended, payment suspension must be discontinued unless there are other reasons to not resume payment.

5. 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:

        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.

6. Notification of payment suspension will 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).

1) 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.

2) If the provider is not an Individual Provider, coordinate provider notification with DDA Central Office.

7. 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. For multi-client providers a note in their contract folder can also be made at DDA staff discretion.

b. DDA Central Office 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 SSPS SharePoint 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 Central Office 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
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Approved: */s/ Donald Clintsman* Date: April 15, 2017
Deputy Assistant Secretary
Developmental Disabilities Administration