Mississippi Medicaid

Provider Reference Guide

For Part 300

Appeals

This is a companion document to the Mississippi Administrative Code Title 23 and must be utilized as a reference only.

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USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION

Title XIX is part of the federal Social Security Act. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services or when authorized by the Secretary of Health and Human Services. A provider may disclose records or information acquired under the Medicaid program only when the record or information is to be used in connection with a claim, or to verify the utilization of Medicaid benefits and the disclosure is necessary for the proper performance of the duties of any employee of: (a) DOM, (b) any public or private agency or organization under an agreement with DOM in meeting requirements of the Medicaid program, (c) the Attorney General Medicaid Fraud Control Unit, (d) a duly authorized legal hearing, or (e) representative of the Secretary of Health and Human Services office.

If a beneficiary or beneficiary's attorney requests medical records, billing information, etc., these records should be released in accordance with the Third Party Procedures. Providers that are utilizing collection and/or billing agencies should know that DOM and its fiscal agent cannot release information to these companies without a signed release from the Medicaid beneficiary. Information can only be furnished to the provider that provided the service to the Medicaid beneficiary or to a provider's business agent, billing service, or accounting firm that regularly handles claims filing for the provider if the company has a written agreement with the provider and has a confidentiality agreement with DOM that is on file with the fiscal agent.

State law requires that any medical information concerning a Medicaid beneficiary that is released by a provider must contain the following information:

- The person is a Medicaid beneficiary,
- His/her Medicaid identification number, and
- The bill has been paid by Medicaid or will be submitted to Medicaid.

ACCESS TO PUBLIC RECORDS

Public access to records maintained by the Division of Medicaid (DOM) is described in Section 25-61-1 et seq. of the Mississippi Code of 1972, as amended. An exception to this public access for Medicaid purposes is beneficiary specific information which must be kept confidential in accordance with 42 CFR 431.300 through 431.307, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR 160 and 164. Other exceptions may also apply as provided by state and federal law. Provider manuals/bulletins and other DOM information including the complete Medicaid Eligibility Manual, the Title XIX State Plan for the Mississippi Division of Medicaid and certain fee schedules are available for viewing and/or printing on DOM's web site at www.medicaid.ms.gov.

Records furnished to DOM by third parties that may contain trade secrets or confidential commercial or financial information will not be released until notice to the third party has been given. Such records will be released within a reasonable period of time, unless the third party has obtained a court order protecting the records as confidential. If the third party notifies DOM that it will seek a court order to protect the records as confidential, DOM will notify the requestor.

Information not accessible through the web may require the assistance of DOM staff to accommodate the request. In those instances, a fee may be charged for the requested information.

DOM staff will respond to the requested public record within seven (7) working days from the date of receipt of the request. In those instances where the public record cannot be produced by the seventh working day after the request is received, DOM staff will provide to the requestor a written explanation as to why the record cannot be produced within the seven-day period. Unless there is mutual agreement of both parties, DOM will provide the requested records within fourteen (14) working days. DOM may require payment prior to production of the public record(s).

PROCEDURE FOR REQUESTING PUBLIC INFORMATION/ FEES

Procedures to request information from DOM include the following:

1. Any person seeking a public record pursuant to the Mississippi Public Records Act, Section 25- 61-1, et seq., should make the request in writing on DOM's request form, which is available for use at the office of the public information officer and online at www.medicaid.ms.gov, or by letter, fax, or e-mail addressed to:

Public Information Officer
Walter Sillers Building
Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
Fax: (601)359-9153
Email: Request.info@medicaid.ms.us

The written request should include the following information:

- Name of requestor;
- Address of requestor;
- Other contact information, including telephone number and any e-mail address;
- Identification of the public records adequate for the public records officer or designee to locate the records;

- The date and time of day of the request.

2. The following fees may be charged for requested information:

   - $10.00 per hour or any part of any hour for clerical staff time
   - $40.00 per hour or any part of any hour for professional staff time
   - $0.15 per page for copies
   - $1.25 per page for FAX
   - $7.00 per CD or DVD

   An additional charge is added for postage costs.

3. Medicaid fee schedules (not available on the web) are available for the following fees:

   Hard Copy - $92.00 (including postage)
   CD - $45.78 (including postage)

   Those requesting only a specific portion of the fee schedule are billed for copying costs, postage, and clerical staff time as outlined above in item 2.

4. If the requested information must be obtained from DOM system files (MMIS), the cost is $85.00 per hour to generate the information requested by writing the proper computer program. Thereafter, copies are made at $0.15 per page. A certified check, money order, or cash shall be deposited in escrow with the DOM staff accountant before retrieval of the information begins. This payment is to cover the cost of the professional staff member's assistance, postage, copying fees, and/or cost of the computer time (see item 2 for specific fees).

5. When required, those inspecting records are provided adequate space to work at no cost.

6. Staff of the Division of Medicaid provides requested records and information.

7. No more than two persons requesting information per organization are assisted at a time.

8. Those requesting to bring in a copier to make their own copies are charged for clerical and/or professional staff time necessary to provide the information for copying.

9. Those requesting to provide clerical staff to make their own copies on DOM copiers are charged $0.15 per page for copies plus clerical and/or professional staff time necessary to provide the information for copying. Copies have to be made during times when DOM staff is not in need of the copiers for agency business.

REVIEW OF DENIALS OF PUBLIC RECORDS

Denials of request for public records will be made in writing and will contain a statement of the specific exemption relied upon for the denial. Any person who objects to the initial denial or partial denial of a records request may petition in writing to the public records office for a review of that decision. The petition must include: (1) a copy of the written statement by the public officer denying the request; and (2) a detailed statement of why the request should be approved, including any legal and/or factual arguments in favor of approving the request.

The public records officer shall submit the petition and any other relevant information to the Executive Director for review. The Executive Director will immediately consider the petition and either affirm or reverse the denial within ten (10) business days following DOM's receipt of the petition.

MAINTENANCE OF RECORDS

All professional, institutional, and contractual providers participating in the Medicaid program are required to maintain all records that will disclose services rendered and/or billed under the program and, upon request, make such records available to representatives of CMS, DOM, the Attorney General Medicaid Fraud Control Unit, or DHHS in substantiation of any and all claims.

GENERAL REQUIREMENTS FOR ALL RECORDS

Records must also be legible, appropriate, and correct. All entries within a medical record should be written legibly to ensure beneficiary safety and appropriate billing or reviewing. All information contained within a medical record should be written or otherwise compiled on appropriate provider documentation forms. All entries within the medical record should be made without a space between entries. Corrections and late entries, when absolutely necessary, should be documented appropriately, as evidenced below. Every effort should be made to make correct and timely entries initially in the medical record. All entries must be made in a permanent form such as indelible ink. Entries made in pencil are not acceptable. At no time should corrective tape, corrective liquid, erasers or other obliteration supplies be used to remove or change information on or in the medical record. A medical record is a legal document and it is illegal to tamper with or falsify such documents.

ENTRY CORRECTION:

- Draw a single line through the error making certain that the error entry, though crossed out, is still legible.

- Initial and date/time when the entry was marked out.
- Enter the correct information in a new entry on the next available line or in the next available space. The current date/time should be used when beginning this entry. The time the event/incident occurred can be placed within the entry text itself.
- Never use corrective tape, corrective liquid or other obliteration supplies to change or erase any part of the medical record.

LATE ENTRIES:

- Identify the new entry as a "Late Entry" in the medical record.
- Enter the current date and time when the entry is actually being written in the medical record. (This should not be the date and time the incident/event actually occurred.)
- Identify the incident and refer to the date and time that the incident occurred within the late entry.
- Document information as soon as possible.
- Never use corrective tape, corrective liquid or other obliteration supplies to change or erase any part of the medical record.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. Refer to specific program sections for detailed documentation requirements.

DOM staff shall have immediate access to the provider's physical services location, facilities, records, documents, books, prescriptions, invoices, radiographs, and any other records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours (8 a.m. to 5 p.m., Monday – Friday) and all other hours when employees of the provider are normally available and conducting the business of the provider. DOM staff shall have immediate access to any administrative, maintenance, and storage locations within, or separate from, the service location.

ABSENCE OF ADEQUATE RECORDS TO VERIFY SERVICES

If a provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for such nonsubstantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

RECORD RETENTION REQUIREMENTS

Providers must maintain compliance with the MS Code as follows:

- **Section 43-13-117:** "Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report."

- **Section 43-13-118:**"It shall be the duty of each provider participating in the medical assistance program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its claim for services rendered Medicaid recipients, and such books, documents, and other records shall be kept and maintained for a period of five (5) years or for whatever longer period as may be required or prescribed under federal or state statutes and shall be subject to audit by the Division. The Division shall be entitled to full recoupment of the amount it has paid any provider of medical service who has failed to keep or maintain records as required herein."

NOTE: ALL providers must maintain records that substantiate claims for services rendered and/or billed under the program for a minimum of five (5) years. The minimum three (3) year retention requirement for records that substantiate cost reports applies only to cost reports AND only to the aforementioned providers.

FRAUD ABUSE

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.

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:

- Name and address of the affected provider;
- 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.
- Provider Identification Number(s) associated with claims;
- Tax Identification number(s);
- Payee Identification number(s);
- 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)
- 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;
- The self disclosure should include a detailed account of the provider's investigation of the overpayment.
- A statement disclosing whether the provider is under investigation by any government agency or contractor;
- A statement detailing the provider's theory regarding the cause of the violation;
- 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;

- 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).

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:

- Lump sum payment by the provider.
- Offset against current payments due to the provider.
- A repayment agreement executed between the provider and DOM.
- 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:

- The overpayment is recovered;
- The DOM enters into an agreement with the provider for repayment of overpayments.
- 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 ninety (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.
- 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:

- Qualifications of Medicaid RACs;
- Required personnel;
- Contract duration;
- RAC responsibilities;
- Timeframes for completion of audits/recoveries;
- 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.

FUNDRAISING

Fundraising may only be used to obtain funds needed to pay for medical/treatment costs not normally covered by the Mississippi Medicaid program. Such costs include, but are not limited to the following:

- Transportation for family members
- Food and lodging for the beneficiary and family
- Child care
- Non-covered medical equipment
- Non-covered medical services

FUNDRAISING CRITERIA

- Prior to accepting donations arrangements must be made to place donations in a trust fund/ special account

- The trust fund/special account must be established/administered in compliance with all applicable federal and state rules/regulations

- The trust fund/special account must be managed/administered by someone other than the beneficiary or the beneficiary's family member/legal guardian (i.e., the beneficiary or the beneficiary's family member/legal guardian may not have direct access to the fund/account)

- The trust fund/special account must be maintained separate from personal monies belonging to the beneficiary or the beneficiary's family member/legal guardian (i.e., mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits)

- Legible documentation on income and expenditures must be maintained and must be made available to the Division of Medicaid, the fiscal agent, and/or the UM/QIO upon request

The beneficiary must report all sources of income to the source of eligibility. The source of eligibility will inform the Third Party Liability Unit of the availability of any other source of payment for medical services. Donated funds for the purpose of payment of medical services are considered a third party source. Provider/facilities must adhere to conditions of participation as a Medicaid provider and cannot participate in fundraising for beneficiaries to raise additional funds to pay for Medicaid covered procedures and/or related services.

"The provider must agree to accept as payment in full the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid only where Medicaid covers said services, unless some other resources, other than the beneficiary, or the beneficiary's family will pay for the service."

LIMITED ENGLISH PROFICIENCY PLAN

For Division of Medicaid purposes, this plan is established to define the compliance requirements mandated by Title VI of the Civil Rights Act of 1964 U.S.C. section 2000(d),

pertinent to the provision of services to individuals with limited English proficiency (LEP), established procedures for requisitioning forms in Spanish and Vietnamese, and for accessing and/or hiring and utilizing qualified interpreters. This policy provides provisions to ensure awareness of the program by beneficiaries/applicants with limited English proficiency, employee training and requirements for reporting, records retention for the LEP program and monitoring oversight of the language assistance program to ensure LEP persons meaningful access to the program.

The LEP Plan is located on the Division of Medicaid website at www.medicaid.ms.gov. Click on the Limited English Proficiency Plan link on the left hand side of the webpage.

AUDIT POLICY

GENERAL

The bureaus under the Office of Audit and Recovery are responsible for conducting auditing and monitoring reviews of Medicaid providers. Those bureaus include: Financial and Performance Audit, Program Integrity, and Third Party Recovery. It is the mission of the Office of Audit and Recovery to ensure compliance, efficiency, and accountability within the Mississippi Medicaid program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance.

AUDIT AND MONITORING REVIEWS

The Office of Audit and Recovery utilizing bureau staff, contracted audit entities or combination of both, selects Medicaid providers for review. An audit or monitoring review has the following objectives:

1. To determine if services billed and paid under the State's Medicaid program were:

    - Provided to an eligible beneficiary;
    - Medically necessary;
    - Provided at the appropriate level of care;
    - Appropriately documented;
    - In accordance with the Mississippi Medicaid Provider Manual, Mississippi State Plan, and official notices through other means such as, but not limited to, the Mississippi Medicaid Provider Bulletin, Remittance Advice header messages, and official communications from the Agency; and

- For service for which the reimbursement rate is based on a cost report, that the cost report contains only allowable costs and were completed in accordance with the Mississippi Medicaid Provider Manual and Mississippi State Plan.

2. To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations

3. To provide a mechanism for data gathering which can be used to modify the State's Medicaid program and State Medicaid Policies and Procedures;

4. To determine if the services provided meet the community standard of care; and

5. To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the review period.

AUDIT METHODS AND LOCATIONS

The Office of Audit and Recovery selects the appropriate method of conducting the review including, but not limited to, the following:

- On-site reviews, conducted on the provider's premises;
- Desk audits, conducted at DOM's or Contracted auditor's offices; or
- A combination of an on-site and a desk audit.

AUDIT/MONITORING REVIEW OVERVIEW

Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client;
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;
- Make charts and records available to Medicaid staff, it contractors, and the U.S. Department of Health and Human Services upon request. Records shall be maintained in accordance with Mississippi Medicaid Provider Policy.

A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

If a provider fails to participate or comply with DOM's audit process or unduly delays the audit process, DOM considers the provider's actions or lack thereof, as abandonment of the audit.

If DOM suspects a provider of fraud, abusive practice, audit abandonment, or presents a risk of imminent danger to clients, DOM may take one or more of the actions listed below.

- Immediately issue a final report;
- Terminate the provider's agreement with Medicaid;
- Issue a subpoena for the provider's records
- Refer the provider to the appropriate prosecuting authority.

AUDIT/MONITORING REVIEW PROCESS

In general, the audit/monitoring review process will be as follows:

Provider Notification - Generally, DOM will provide written notice of the audit/review thirty (30) calendar days prior to commencement of the audit/review. Exceptions to the thirty day advance notice requirement include, but are not limited to:

- Resident trust fund reviews;
- Desk reviews;
- The provider is suspected of fraud or abuse;
- DOM believes that the provider's actions endanger the health or safety of patients or others.
- The notification will detail the program being reviewed, the audit period(s), the Medicaid provider number(s) and a documentation/materials request list. The documentation/materials request list will detail the information that will need to be submitted prior to the commencement date and the documentation that will be required once Audit and Recovery staff is on-site.

The provider notification will also detail the number of audit/review staff that will be on-site and the expected timeframe of the audit/review. Providers are expected to accommodate audit/review staff with acceptable workspace.

Field Entrance Conference – A field entrance conference will be held with designated provider staff. During the entrance conference, the lead auditor/reviewer for DOM will discuss the

audit/review process, the requested documentation, workspace, provider contacts for questions/information requests, and any other items deemed necessary.

Procedures for Submitting Documentation Electronically – Providers are required to follow all HIPAA regulations regarding the use and disclosure of Protected Health Information (PHI). If a provider chooses to submit documentation electronically, it must be submitted through DOM's secure website to protect PHI. Providers should contact Audit and Recovery with any questions on proper procedures for submitting documentation electronically.

Examination of Documentation – During the review, audit/review staff will review requested documentation. Once on-site, audit/review staff will request additional documentation necessary to complete the audit/review. Providers are expected to provide information requested in timely manner.

Field Exit Conference – At the conclusion of the on-site review, audit/review staff will conduct a field exit conference with designated provider staff. During the exit conference, the lead auditor/reviewer for DOM will discuss as appropriate, proposed adjustments and/or findings. All proposed adjustments/findings are subject to review prior to issuance of the final report. If additional information is required, Audit and Recovery staff will submit to the provider a documentation request list and a timeline for providing the information. Providers will have a maximum of two (2) weeks from the field exit conference date to produce additional files and records. Upon review of the outstanding documentation, if it is determined that additional items are needed; the provider will have a maximum of two (2) weeks from the date of notification to submit the documentation.

Draft Report – Upon completion of the review of all documentation submitted by the provider, DOM will issue a draft report to the provider detailing the proposed adjustments and/or findings. The provider has thirty (30) calendar days from the date of delivery to submit a response to the adjustments and/or findings. The provider shall submit their response and additional documentation to DOM Audit and Recovery by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery**.** In their response, if the provider is contesting any adjustments or findings, their response should:

- Specify which adjustments/findings are being contested;
- Supply documentation to support the provider's position.

During the thirty (30) day response time, the provider may submit questions in writing to DOM. Requests for time extensions must be in writing and are not guaranteed.

DOM will review the provider's response and any additional documentation provided. DOM will prepare a response to the provider and inform the provider of any changes that were made or an explanation will be provided if no changes were made. DOM will also contact the provider to schedule an exit conference. The exit conference will be held within 10 business days of contact by DOM.

If the provider does not respond to the draft report within thirty (30) days, DOM will offer the provider an opportunity for an exit conference. In addition, DOM will issue the final report to the provider.

Exit Conference – An exit conference will be held with the provider to communicate the results of the audit and the adjustments and/or findings that will be in the final report.

Final Report – DOM will issue a final report to the provider via certified mail, return receipt requested. The final report will detail all adjustments and findings resulting from the review. The report will include a letter informing the provider of their rights to an administrative hearing.

FALSE CLAIM ACT

GENERAL

Section 6032 of the federal Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) set forth administrative requirements which impacts entities receiving annual Medicaid payments of at least $5,000,000. The DRA requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to provide employee education regarding the False Claims Act and take actions that will address fraud, waste and abuse in health care programs that receive federal funds. Any entity that receives $5,000,000 or more annually must establish the following policies as a condition of participation in the Medicaid program:

- The entity must establish written policies for all employees of the entity (including management), and of any contractor or agency of the entity, that provides detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code.
- The entity must include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- The entity must include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Annually, the Division of Medicaid (DOM) will identify and mail notices to providers and contractors that provide Medicaid health care items or services that were paid $5,000,000 or more during the prior federal fiscal year. The $5,000,000 threshold will be measured based upon the aggregate payments received by an entity during the federal fiscal year (October 1 – September 30), even if that entity has multiple provider and/or tax id numbers. For example, a health system that includes a hospital, skilled nursing facility and home health program and collectively receives more than $5,000,000 in aggregate reimbursement annually will be subject to this requirement. Once notified, the entity will have thirty (30) calendar days to submit the documentation requested in the letter to confirm compliance.

It is the responsibility of each entity meeting the annual threshold to establish and disseminate written policies. In addition, the entity must provide those policies to the DOM including any revisions. The DOM will perform annual monitoring activities to ensure that entities are in compliance with this section. Providers will be selected on a random basis or as needed.

If an employee or contractor or agent of an entity reports suspected fraud, waste, or abuse in the Medicaid program, the entity must report that information to the Bureau of Program Integrity at the Division of Medicaid by the next business day. Entities must investigate all allegations within a reasonable time period and report the results of the investigation to the Division.

SANCTIONS

If an entity is found not to be in compliance with any part of the requirements noted above, the provider will be given a thirty (30) day notice by the DOM that suspension of the entity's provider number(s) and payment may be held at the sole discretion of the DOM. The entity must submit appropriate documentation to the satisfaction of the Division of Medicaid in order for the non-compliance status to be lifted. The DOM will work in conjunction with the Attorney General's office and the Office of the Inspector General (OIG) on cases of non-compliance.

DEFINITIONS

Entity- An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payment, under a State Plan approved under title XIX or under any waiver of such plan. In addition, persons are considered entities. A "person" includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business or trust.

If an entity furnishes items or services at more than a single location or under more than once contractual or other payment arrangement, the provisions of this section will apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

Employee- An "employee" includes any officer or employee of the entity.

Contractor or Agent- A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

Knowingly- "Knowing" and "Knowingly" is defined to mean that a person has actual knowledge of falsity of information in the claim; Acts in deliberate ignorance of the truth or

falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in the claim.

The federal False Claims Act does not require proof of a specific intent to defraud the United States government. Instead, entities can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to Medicaid. Examples include knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

Whistleblower - An individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under Sections 31 USC 3729 through 3733 which is based on the information.

Claim - A "claim" includes any request or demand for money that is submitted to the Division or its fiscal agent.

APPEALS

To obtain additional information regarding the False Claims Act, refer to the following websites:

- www.gpoaccess.gov/plaws/index.html
- www.gpoaccess.gov/uscode/index.html