PROGRAM INTEGRITY

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal government and state government have enacted laws, promulgated rules and regulations, and the Department of Health and Hospitals (DHH) has established policies concerning fraud and abuse. It is the responsibility of the provider to become familiar with these laws, rules, regulations, and policies. This section was developed to assist the provider in becoming familiar with this vital information; but it is not all-inclusive, nor does it constitute legal authority.

Providers, recipients, and others may be subject to criminal prosecution, civil action, and/or administrative action for the violation of laws, rules, regulations, or policies applicable to the Medicaid Program. Federal laws and regulations and state laws require that the Medicaid Program establish criteria that are consistent with recognized principles that afford due process of law where there may be fraud, abuse or other incorrect practices. These laws and regulations also stipulate as well as arrange for the prompt referral to the proper authorities for investigation or review and authorize the DHH to conduct reviews of claims before and after claims are paid.

Generally, suspected criminal activities are investigated and prosecuted by the Medicaid Fraud Control Unit (MFCU) of the Attorney General's (AG) Office. Civil actions are investigated and initiated by the DHH and/or the AG's Office. Administrative actions are investigated and initiated by the DHH. Depending on whether the action is criminal, civil, or administrative, different standards of proof and levels of due process apply.

Program Integrity Section

The purpose of the Program Integrity Section is to assure the programmatic and fiscal integrity of the Louisiana Medical Assistance Program. In order for the DHH to receive federal funding for Medicaid services, federal regulations mandate that DHH perform certain program integrity functions. The primary functions of the Program Integrity Section are:

- Provider Enrollment
- Fraud and Abuse Detection
- Investigations
- Enforcement
- Administrative Sanctions
- Payment Error Rate Measurement (PERM)

The mandates that direct the functions of the Program Integrity Section can be found in:

- Federal laws and the Code of Federal Regulations;
- RS 46:437.1 - 440.3, the Medicaid Assistance Program Integrity Law (MAPIL);
- Title 50, Part I, Subpart 5, Chapter 41 of the Louisiana Administrative Code (LAC 50:I.Chapter 41.) – the Surveillance Utilization Review System (SURS) Rule;

Provider Enrollment Unit

The fiscal intermediary is responsible for processing completed **provider enrollment** packets submitted by health care services providers requesting enrollment to participate in the Medicaid Program to provide specific types of services to Medicaid recipients. If eligible for enrollment, a provider is assigned a separate Medicaid provider number for each specific type of service. Provider enrollment packets and other forms are available online under the Provider Enrollment link on the Louisiana Medicaid website. (Refer to the Appendix B for contact information)

Fraud and Abuse Detection

When providers bill Medicaid, claims are paid using the **Medicaid Management Information System (MMIS**). A monthly data extraction of the claims processing system information is put into a relational data base. This data is then "mined" to detect abnormal billing practices.

Complaints may also be used to detect fraud or abuse. Complaint procedures are designed for use by interested parties to bring problems encountered with providers to the attention of the Program Integrity Section.

The Program Integrity Section receives complaints from providers, private citizens, other agencies or offices within DHH through the Fraud and Abuse Hotline, the DHH website or through written reports

The state has a toll-free hotline for reporting possible fraud and abuse in the Medicaid Program. Providers are encouraged to provide the hotline number to individuals who want to report possible cases of fraud or abuse. (Refer to Appendix B)

Investigations

An investigation is a review process where documents are compared to the requirements established by law, regulations, written policies and directives for a particular service. An investigation is opened: when questionable information is received as a result of data mining, or based on the information received from a complaint, or at the request of the Department.

The Program Integrity Section requests additional information from the provider when an investigation is opened. The type of information requested is determined by the type of investigation that is opened.

Medicaid has an absolute right to the records that are related to Medicaid recipients. If records are requested through written notification, the provider is responsible for the cost of copying and mailing the information to the Program Integrity office. If records are requested at an on-site review, the provider must make all requested records available to the Program Integrity staff.

The following provider errors are commonly noted during investigations.

- **Services Not Documented** – No documentation to support the billed services were ever provided to the recipient.
- **Medical Necessity Not Supported** – Documentation in the record does not support the medical necessity of the service billed.
- **Inferior Record Keeping** – Provider records are not in compliance with the requirements of the Medicaid program.
- **Up-coding** – Documentation in the record does not support the higher level of service billed.
- **Unbundling of Services** – Services were billed individually when they should have been billed as part of a group of services.

Administrative Actions

Federal and state laws and regulations assign responsibility and authority to the Department to bring administrative actions against providers, recipients and others who engage in fraudulent, abusive and/or other incorrect practices.

Enforcement/Sanctions

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed either prior to or after payment is made by the Bureau. Administrative sanctions may be imposed against any Medicaid provider who does not comply with laws, rules, regulations, or policies.

Sanctions refer to administrative actions taken by the Bureau against a provider. Sanctions are designed to remedy inefficient and/or illegal practices that do not comply with the Department's policies and procedures, statutes, and regulations.

Sanctions which may be imposed through the administrative process include, but are not limited to the following actions.

- Denial or revocation of enrollment

- Recommendation of revocation of licenses and/or certificates
- Withholding of payments
- Exclusion from the Medicaid Program
- Recovery of overpayments and imposition of administrative fines

Grounds for Sanctioning Providers

The Bureau may impose sanctions against a provider if any of the following conditions occur:

- A provider is not complying with the Department's policies, rules, and regulations, or the provider agreement that establishes the terms and conditions applicable to each provider's participation in the program;
- A provider has submitted a false or fraudulent application for provider status;
- A provider is not properly licensed or qualified, or a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated;
- A provider has engaged in a course of conduct; or has performed an act for which official sanction has been applied by the licensing authority, professional peer population, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing authority indicating that the conduct should cease;
- A provider has failed to correct deficiencies in the delivery of services or billing practices after having received written notice of these deficiencies from the Bureau;
- A provider has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to **Public Law 95-142**, or has been convicted of Medicaid fraud (**Louisiana R.S. 14:70.1);**
- A provider has been convicted of a criminal offense relating to performance of a provider agreement with the State, to fraudulent billing practices, or to negligent practice resulting in death or injury to the provider's patient;
- A provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
- A provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which Medicaid has already made a payment;

- A provider has rebated or accepted a fee or a portion of a fee for a patient referral;
- A provider has failed to repay or arrange to repay an identified overpayment or otherwise erroneous payment within ten working days after the provider receives written notice;
- A provider has failed, after having received a written request from the Bureau, to keep or to make available for inspection and audit, copies of records regarding claims filed for payment for providing services;
- A provider has failed to furnish any information requested by the Bureau or the fiscal intermediary regarding payments for providing goods and services
- A provider has made, or caused to be made, a false statement or a misrepresentation of a material fact concerning the administration of the Louisiana Medicaid Program;
- A provider has furnished goods or services to recipients that are in excess of the recipient's needs, not medically necessary, harmful to the recipient, or of grossly inadequate or inferior quality (This determination would be based upon competent medical judgment and evaluation.);
- Being found in violation of or entering a settlement under MAPIL;
- Failure to cooperate with the Bureau, its fiscal intermediary or the investigation officer during the post-payment or pre-payment process, an investigatory discussion, informal hearing or the administrative appeal process or any other legal process;
- Submitting bills or claims for payment or reimbursement to the Louisiana Medicaid Program on behalf of a person or entity which is serving out a period of exclusion from Medicaid, Medicare or any other publicly funded health care program.
- Engaging a systematic billing practice, which is abusive or fraudulent and which maximizes costs to the Louisiana Medicaid Program after written notice to cease;
- Failure to meet the terms of an agreement to repay or a settlement agreement entered into under MAPIL or the SURS rule;
- A provider, or a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporation, an owner of a sole proprietorship, or a partner in a partnership that is found to fall into one or more of the following categories;

    - Was previously barred from participation in the Medicaid Program;
    - Was a person with management responsibility for a previously terminated provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid Program;

- Was an officer or owner (directly or indirectly) of 5% or more of the shares of stock or other evidences of ownership or owner of a sole proprietorship or a partner of a partnership that was a provider during the time of conduct that was the basis for that provider's termination from participation in the Medicaid Program;
- Was engaged in practices prohibited by federal or state law or regulation;
- Was a person with management responsibility for a provider at the time that the provider engaged in practices prohibited by state or federal law or regulation;
- Was convicted of Medicaid fraud under federal or state law or regulation;
- Was a person with management responsibility for a provider at the time that the provider was convicted of Medicaid fraud under federal or state law or regulation;
- Was an officer or owner (directly or indirectly) of 5% or more of the shares of stock or other evidences of ownership; or sole proprietorship or a partnership that was a provider at the time the provider was convicted of Medicaid fraud under federal or state law or regulation; or
- Was an owner of a sole proprietorship or partner in a partnership that was a provider at the time such a provider was convicted of Medicaid fraud under federal or state laws and regulations.

NOTE: This list is not all-inclusive.

Federal laws and regulations also provide for administrative actions. Providers should refer to applicable federal laws and regulation and applicable sanctions.

Levels of Administrative Actions and Sanctions

The Bureau may impose corrective actions and/or administrative sanctions against a Medicaid provider.

Corrective Action Plans

The Bureau may at any time issue a notice of corrective action to a provider. The provider shall either comply with the corrective action plan within ten working days or request an informal hearing within that time. The purpose of the corrective action plan is to identify potential problem areas and correct them before they become significant discrepancies, deviations or violations.

Sanctions

Sanctions may include:

- Issuing a warning;
- Requiring education and training at the provider's expense;
- Limiting the services that may be provided or the individuals to whom the services are provided;
- Requiring recoupment;
- Requiring recovery;
- Imposing judicial interest on outstanding recoveries or recoupment;
- Imposing reasonable costs;
- Excluding an individual or entity from participation;
- Suspending an individual or entity from participation;
- Requiring forfeiture of a posted bond;
- Imposing an arrangement to repay;
- Imposing monetary penalties not to exceed $10,000;
- Imposing withholding of payments;
- Requiring the provider receive prior authorization for any or all goods, services or supplies;
- Imposing fines and costs; or
- Requiring bonds or other forms of security.

NOTE: This list is not all-inclusive.

The provider should refer to the laws and regulations related to sanctions for each program for which enrolled and should review the LAC 50:I., Chapter 41, Subchapter E.

Exclusions

Exclusion from the Medicaid Program may be either mandatory or permissive. Health care fraud is a mandatory exclusion. Permissive exclusions include other crimes and activities as contained in the SURS Rule for which an individual and/or entity may be excluded from Medicaid.

Screenings for Exclusions and Sanctions

The Office of Inspector General (OIG), under its Congressional mandate, established a program to exclude individuals and entities affected by the various legal authorities, contained in Section 1128 and 1156 of the Social Security Act. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities.

Under the SURS Rule, providers have an obligation to ensure their employees are not and have not been excluded, restricted or convicted of a crime relative to a government funded health program. Providers should check the OIG and the Excluded Parties List System (EPLS) websites to determine if an individual has been excluded, restricted or convicted. (Refer to Appendix B for contact information)

Background Checks

Providers should perform background checks on all managers and employees in addition to contacting licensing boards at the time of hire and periodically thereafter. Failure to do these checks will result in the provider being sanctioned and subject to recovery, fines and possible exclusion from Medicaid.

Fraud

Federal regulations and the SURS Rule prohibit individuals and/or entities that have been excluded from a government funded health program and/or convicted of health care fraud from participating in Medicaid or any other federally funded health care program.

Practice Restrictions

The SURS Rule mandates that when a restriction is placed on an individual or entity by another governing board, Medicaid will place a restriction on the individual or entity as well.

Informal Hearings and Appeals

An informal hearing is held at the request of a provider and is generally conducted by Program Integrity. This is not a court proceeding, but a discussion on what information and records were used in the review. Providers may opt to have legal representation, but it is not required.

After the informal hearing, providers receive a written notice of the results of the hearing and the recommended action to be taken. If the recommended action is accepted, the administrative process ends and the recommended action will be implemented. If the recommended action is rejected, the provider may initiate an appeal hearing which will be scheduled by the Division of Administrative Law-Health and Hospitals Section.

The Department of Health and Hospitals offers an opportunity to have a hearing to any provider who feels that he/she has been unfairly sanctioned. The Division of Administrative Law-Health and Hospitals Section are responsible for conducting hearings for providers who have complaints. Requests for hearings should be made in writing and explain the reason for the request. All requests should be sent directly to the Division. (Refer to Appendix B for contact information)

Information regarding the appeals procedure may also be obtained by contacting the Division.

Criminal Fraud

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. In criminal proceedings, the definition of fraud that governs between citizens and state government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.1.

Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142. Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All legal action is subject to due process of law and to the protection of the rights of the individual under the law.

Federal law also defines what is considered criminal conduct within federally funded programs. All providers should be aware of the applicable federal laws and regulations.

Provider Criminal Fraud

Cases involving one or more of the following situations shall constitute sufficient grounds for a provider fraud referral:

- Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid patients;
- Billing for supplies or equipment that are unsuitable for the patient's needs or are so lacking in quality or sufficiency as to be virtually worthless;
- Claiming costs for non-allowable supplies, or equipment disguised as covered items;
- Misrepresenting dates and descriptions of services rendered, the identity of the provider or of the recipient;
- Submitting duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
- Arrangements made by providers with employees, independent contractors, suppliers, and others (through various devices such as commissions and fee splitting) which appear to be designed primarily to obtain or conceal illegal payments, and/or additional or duplicate reimbursement from Medicaid.

NOTE: The above list is not all inclusive, but is rather illustrative of practices which may be considered criminal activities.

Recipient Criminal Fraud

Cases involving one or more of the following situations shall constitute sufficient grounds for a recipient fraud referral:

- The misrepresentation of facts in order to become eligible, remain eligible or to receive greater benefits under the Medicaid Program;
- The transfer of a Medicaid Eligibility Card to a person not eligible to receive services or to a person whose benefits have been restricted or exhausted, thus enabling the person to receive unauthorized medical benefits; and
- The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

NOTE: The above list is not all inclusive, but is rather illustrative of practices which may be considered criminal activities.

Abuse and Incorrect Practices

Abuse by providers, recipients, and others include practices that are not criminal acts, but still represent the inappropriate use of public funds.

Provider Abuse and Incorrect Practices

Cases involving one or more of the situations listed below may constitute sufficient grounds for investigation of a provider for incorrect practices or abuse. Abuse includes:

- The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the recipient of the services, or of the individual who rendered the services and gained a larger reimbursement than is entitled; and
- The solicitation or subsidization of anyone by paying or presenting any person with money or anything of value for the purpose of securing patients. Providers, however, may use lawful advertising that abides by the Bureau's rules and regulations.

NOTE: This list is not all-inclusive, but is rather illustrative of practices that are abusive or improper.

Recipient Abuse

Cases involving one or more of the following situations may constitute sufficient grounds for a recipient abuse referral. Providers are required to report to the Bureau suspected cases of recipient abuse related to the unnecessary or excessive use of:

- Prescription medication benefits of the Medicaid Program;
- Physician benefits of the program; and
- Other medical services and/or medical supplies that are benefits of the program.

Civil Causes of Action

The Medical Assistance Program Integrity Law (MAPIL), RS 46:437.1-46:440.3 provides for civil causes of action that can be taken against providers and others who violate the provisions of MAPIL. MAPIL prohibits illegal remuneration, false claims, illegal acts regarding eligibility, and recipient lists among other things. These civil causes of action are set forth in RS 46:438.1-46:438.5. Individuals who are found by a court of law to have violated the provision of MAPIL are subject to triple damages, fines, cost, and fees.

Payment Error Rate Measurement

The Improper Payments Information Act of 2002 directed federal agencies to annually review programs that are susceptible to significant erroneous payments and report these improper payment estimates to Congress. The Centers for Medicare and Medicaid Services (CMS) uses a 17-state rotation for payment error rate measurement (PERM).

Each state is reviewed once every three years. This rotation allows states to plan for the review as they know in advance when they will be measured. CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected State Medicaid and CHIP (Children's Health Insurance Plan) fee-for-service (FFS) and managed care claims.

States are responsible for performing their own eligibility reviews using state and federal criteria. Reviews are made to determine the accuracy of recipient eligibility along with payments for services rendered. This information is then sent to CMS to be used to determine a state and national error rate.