MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 19, 2008

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE /John A. Liveratti/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3300 – PROGRAM INTEGRITY

BACKGROUND AND EXPLANATIONS

The proposed revision to Chapter 3300 is due to a change in federal regulation regarding the Payment Error Rate Measurement (PERM) program. Chapter 3300 was revised in May 2007 based on information contained in the interim final rule (published in the Federal Register, August 28, 2006) which called for a 90 day timeframe in which providers would be required to submit medical record documentation. The Federal Register of August 31, 2007 contained the final rules for the PERM program. The final rules did not state the exact revised timeframe, but intimated it might be changed to 60 days and indicated that a policy instruction might be issued for clarification. Therefore, in order to provide the most up to date information to medical providers, Chapter 3300 was revised. Additionally, providers have been notified via First Health web messages and information in First Health provider newsletters of the change in submittal timeframes. Since the federal PERM reviews have not started in Nevada, no providers have been impacted by this revised policy.

MATERIAL TRANSMITTED **MTL 04/08** CHAPTER 3300 – PROGRAM INTEGRITY	MATERIAL SUPERSEDED **MTL 19/07** CHAPTER 3300 – PROGRAM INTEGRITY
Sec. 3302.2B Added comma after “type”	Deleted “90 days of the initial request for documentation.”
Added “the timeframes specified in the Payment Error Rate Measurement (PERM) Final Rule (released in the Federal Register on August 31, 2007) or any subsequent policy instruction by CMS.	

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3300 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) is responsible for the fiscal integrity of the Medicaid and Nevada Check Up programs and is committed to a program that identifies and reduces fraud, abuse and improper payments. The DHCFP must ensure Medicaid and Nevada Check Up recipients have access to quality care and claims are paid appropriately and in accordance with state statutes and federal laws and regulations, program policies and billing manuals. The DHCFP has three distinct programs to assist in ensuring the fiscal integrity of the programs it administers: the Surveillance and Utilization Review (SUR) program, the Payment Error Rate Measurement (PERM) program and the Financial and Compliance Audit program.

Surveillance and Utilization Review

Federal regulations require the DHCFP to operate a statewide SUR program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in an efficient, economical and effective manner. The DHCFP has methods in place to: identify, investigate and refer suspected cases of provider and recipient fraud and abuse; methods and processes to review provider over-utilization of services and in the case of managed care providers, under-utilization of services and recover improper payments. The DHCFP will conduct reviews to determine if services were billed in accordance with applicable policies and/or regulations. Providers are selected for review based on complaints, referrals and through the use of fraud detection and other analysis. All providers are at risk for review.

The DHCFP must refer all cases of suspected fraud and abuse, pursuant to Nevada Revised Statutes (NRS) 422.540 to 422.570, to the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU). The MFCU has the primary authority and responsibility to fully investigate and prosecute, for civil and/or criminal action, violations of fraud and abuse in the Medicaid and Nevada Check Up programs.

The Division of Welfare and Supportive Services (DWSS) is responsible for all recipient related Medicaid fraud and abuse, including unlawful acts relating to Medicaid cards. To report any fraudulent activity related to Medicaid recipients contact the Investigations and Recovery Unit within the DWSS or fill out a fraud report on-line at http://welfare.state.nv.us/I&R/ir.htm.

The DHCFP must ensure the exclusion of certain individuals and entities from participation in the Medicaid and Nevada Check Up programs. For the DHCFP policies and applicable state and federal statutes and regulations relating to this process, refer to the Medicaid Services Manual Chapter 100.

The DHCFP must ensure all entities receiving payments of $5 million dollars or more from the Medicaid program establish policies for the entity's employees providing detailed information about: the entity's procedures for detecting and preventing fraud, waste and abuse; false claims;

civil and criminal penalties; and whistle blower protections. For the DHCFP policy relating to this provider requirement, refer to the Medicaid Services Manual, Chapter 100.

Payment Error Rate Measurement (PERM)

The Improper Payments Act of 2002 (IPIA) requires the Centers for Medicare and Medicaid Services (CMS) to estimate improper payments in all state Medicaid and State Children's Health Insurance Programs (Nevada Check Up). CMS must annually calculate and report to Congress the national error rates in each of these programs and the actions it is taking to reduce improper payments in these health care programs. To meet the requirements of the federal mandate, CMS requires each state to undergo a PERM review once every three years. Nevada will be reviewed in federal fiscal year 2008 and every third year thereafter.

PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation. Recipient eligibility reviews will be conducted by the DWSS. The claims processing and medical record or service documentation reviews for the mandated PERM program will be conducted by federal contractors.

Financial and Policy Compliance Audits

The DHCFP will conduct regular financial and policy compliance audits of programs and services provided under the Medicaid and Nevada Check Up programs. These audits consist of a thorough review of program policy, claims processing and/or medical or service record documentation.

3301 REGULATORY AUTHORITY

Provider and recipient fraud, abuse and improper payments are regulated by federal law and state statute, specifically, the Social Security Act (SSA), United States Code (Title 42), Code of Federal Regulation (42 CFR) and the Nevada Revised Statutes (NRS). Specific authorities include, but are not limited to:

Social Security Act (SSA)

a. The penalty for fraud is regulated by Section 1107.

b. Section 1128A outlines civil monetary penalties for acts involving federal health care programs.

c. Section 1128B outlines criminal penalties for acts involving federal health care programs.

d. Section 1902 and Section 2103 govern the amount, duration and scope of medical assistance for Medicaid and Nevada Check Up recipients, respectively.

e. Section 1902 (a) (68) describes the requirements for false claims education for entities receiving $5 million dollars in payments from the Medicaid program. Refer to the Deficit Reduction Act of 2005, Section 6032.

f. Section 1903 and Section 2105 govern federal and other payments to states for Medicaid and Nevada Check Up programs, respectively.

g. Section 1903 (q) describes the requirements of state Medicaid Fraud Control Units (MFCU).

h. Sanctions for non-compliance of provisions relating to managed care are regulated by Section 1932.

Code of Federal Regulations (CFR)

a. 42 CFR Part 431, Subpart Q – Requirements for Estimating Improper Payments in Medicaid and SCHIP.

b. 42 CFR 431.54 (e) - Regulates recipient lock-in for recipients over utilizing services.

c. 42 CFR 431.54(f) - Regulates restrictions such as provider lock-out or suspension for abuse of the Medicaid program.

d. 42 CFR 455 Subpart A - Describes the requirements of Medicaid Agency Fraud Detection and Investigation Programs.

e. 42 CFR 456 Subpart A - Describes the general provisions for utilization control in state or federal health care programs.

f. 42 CFR 456 Subpart B - Describes the requirements of a statewide Surveillance and Utilization Review control program for all Medicaid services.

g. 42 CFR 457.915-.935 - Pertains to fraud detection and investigation associated with the State Children's Health Insurance Program (SCHIP).

h. 42 CFR 1001 - Regulates the mandatory and permissive provider exclusions for state or federal health care programs.

i. 42 CFR 1002 - Includes regulations for state-initiated exclusions from Medicaid programs.

j. 42 CFR 1003 - Provides for the imposition of civil money penalties and other applicable regulations regarding exclusion of individuals or entities from federal or state health care programs.

k. 42 CFR 1005 - Regulates appeals of exclusions, civil money penalties and assessments.

Nevada Revised Statutes (NRS)

a. NRS 193.120-193.150 - Details the types of crimes and punishments associated with fraudulent acts.

b. NRS 228.410 - Established the MFCU, including their duties and powers. The MFCU is responsible for the investigation and prosecution of violations of NRS 422.540-422.570.

c. NRS 357 - Governs false claims submitted to state or local governments.

d. NRS 422.2374 - Details the required cooperation between the DHCFP and the MFCU involving the suspension or exclusion of provider services under Medicaid.

e. NRS 422.305 - Regulates confidentiality of information obtained in investigations of provider of services for Medicaid.

f. Unlawful acts regarding Medicaid cards are regulated by NRS 422.366-422.369.

g. Unlawful acts; fraud by person authorized to provide care to holder of stolen, forged, expired, or revoked card; penalty – are regulated by NRS 422.369.

h. NRS 422.410-422.590 - Covers unlawful acts and penalties related to services provided by or through the DHCFP.

3302 DEFINITIONS

Definitions apply to this Chapter and do not supersede applicable state or federal law.

3302.1 ABUSE

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid or Nevada Check Up programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid or Nevada Check Up programs. (42 CFR 455.2)

3302.2 ADMINISTRATIVE ACTION

Administrative Action is an action taken by the DHCFP which includes but is not limited to: the recovery of improper payments; issuance of educational letters; issuance of warning letters; issuance of recoupment/recovery letters; special claims reviews or on-site audits; requests for provider corrective action plans; requests for provider self audits; referral to appropriate civil agencies (licensing bodies); referral to the MFCU; denial of provider applications; suspension and termination of provider status; and other actions as stated in policy 3303.3A. See the Social Security Act Sections: 1128, 1128A, 1128B, and 1903.

3302.3 FRAUD

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)

3302.4 IMPROPER PAYMENT

An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments include but are not limited to: improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits; payments for ineligible recipients; payments for ineligible, non-covered or unauthorized services; duplicate payments; payments for services that were not provided or received; payments for unbundled services when an all-inclusive bundled code should have been billed; payments not in accordance with applicable pricing or rates; data entry errors resulting in incorrect payments; payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts; payments for non-medically necessary services; payments where an incorrect number of units were billed; submittal of claims for unauthorized visits; and payments that cannot

be substantiated by appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse.

3302.5 KICKBACKS

The offering or receiving of any payments or incentives by/from a provider for referring patients, including illegal cash reimbursements, vacations, merchandise, or personal services. (NRS 422.560)

3302.6 OVERPAYMENT/UNDERPAYMENT

This is an amount paid by the DHCFP, to a provider, which is, in excess of or less than, the amount that is allowable for services furnished under applicable policy, rate or regulation.

3302.7 PERM REVIEW ERRORS

These are payment errors discovered during the course of PERM medical record, processing or eligibility reviews.

3302.8 RECOUPMENT/RECOVERY

Recoupment or recovery is an administrative action by the DHCFP or its fiscal agent to initiate re-payment of an overpayment, with or without advance official notice. Recoupment or recovery can be made by reducing future payments to a provider or by direct reimbursement from the provider.

3302.9 UNBUNDLING

Unbundling is the billing of separate procedure codes rather than one all-inclusive code, when an all-inclusive code is required to be billed.

3302.10 UP-CODING

Up-coding is billing using procedure codes that overstate the level or amount of health care or other service provided.

3303 POLICY

3303.1 IDENTIFICATION OF FRAUD, ABUSE AND IMPROPER PAYMENTS

The DHCFP has methods and criteria to identify and track suspected cases of fraud, abuse and/or improper payments. These methods or criteria must not infringe on the legal rights of persons involved; must afford due process of law; and must comply with federal law and state statutes.

3303.1A COVERAGE AND LIMITATIONS

1. The following activities are the responsibility of the DHCFP:

   a. Conduct regular investigations or reviews of claims or other payments to determine if improper payments have been made or fraud and/or abuse has occurred;

   b. Investigate and track referrals from all sources;

   c. Refer suspected fraud and abuse cases to the MFCU in accordance with the Memorandum Of Understanding (MOU) between the DHCFP and the MFCU and state statutes;

   d. Request and/or monitor provider self-audits;

   e. Assist DHCFP administrative staff, as necessary, in clarification or revision of Medicaid and Nevada Check Up policies to aid in preventing or reducing fraud, abuse and/or improper payments;

   f. Assist with assuring Medicaid recipients receive necessary health or other care services at an appropriate level and quality;

   g. Process and track recoupment or recovery of improper payments or improperly paid claims;

   h. Educate providers about the requirements related to provision of service documentation mandated by the PERM program.

   i. Assist in providing education to providers on proper billing practices;

   j. Assist in assuring provider compliance with DHCFP program policy, Medicaid Services Manual, Medicaid Operations Manual, provider billing manuals and federal law and state statutes;

k. Develop and maintain methodologies to verify services reimbursed by the DHCFP were actually furnished to recipients. The DHCFP fiscal agent sends out approximately 500 notices each month to a random sample of Medicaid and Nevada Check Up recipients receiving services. This is the Verification Of Service (VOS) program. Recipients are asked to notify the DHCFP if the services listed were not received. All recipient responses received by the DHCFP are reviewed and if warranted, investigations are conducted;

l. Take all necessary steps to ensure the fiscal integrity and effectiveness of the programs administered by the DHCFP.

2. Fraudulent acts, false claims or abusive billing practices include, but are not limited to:

a. Knowingly and designedly, by any false pretense, false or misleading statement, impersonation or misrepresentation, obtain or attempt to obtain authorization to furnish services, receive payment for services, receive public assistance, money, property or medical care;

b. Submitting a claim or causing a claim to be submitted, knowing the claim to be false, in whole or in part, by commission or omission;

c. Make or cause to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;

d. Make or cause to be made a statement or representation for use by another in obtaining goods or services pursuant to the state plan, knowing the statement or representation to be false, in whole or in part, by commission or omission;

e. Make or cause to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission;

f. Concealing or failing to disclose knowledge affecting the initial or continued right to any payment or to secure such payment either in greater quantity than is due or when no such payment is authorized or due;

g. Converting part or all of any payment intended for another person to himself/herself;

h. Soliciting, receiving, offer or pay any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for, or to induce any person to make:

   1. Referral of an individual to a provider;

   2. Purchase, lease, order, arrange for or recommend the purchase, lease or order of any item, service good or facility for which payment may be made, in whole or part, under the programs operated by the DHCFP;

   3. Submit or cause to be submitted, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs;

i. Submit a false application for provider status;

j. Submitting false information to obtain compensation for services, supplies or equipment the provider is not entitled to from the programs operated by the DHCFP;

k. Submitting repeated claims for services that are not reimbursable by the DHCFP;

l. Submitting repeated claims from which required information is missing or incorrect;

m. Violating any provision in the DHCFP provider agreement (contract between the DHCFP and the provider);

n. Acts which result in termination, suspension, or exclusion of the provider from other governmental programs;

o. Any acts which violate professional conduct standards adopted by state medical licensure boards and other medical professional organizations;

p. Submitting a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.

q. Submitting a claim for services or items which were not rendered by the provider or were not rendered to an eligible recipient.

r. Submitting a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

s. Except in emergency situations, dispensing, rendering or providing a service or items without a practitioner's written order and the consent of the recipient.

t. Submitting a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.

u. Submitting a claim for medically unnecessary services;

v. Coercion of recipients to sign Verification of Service forms for services not provided;

w. Reporting or billing for hours or services, when services were not provided to the extent reported or billed;

x. False statements include, but are not limited to:

1. Falsification of medical records;

2. Submitting a bill for a service not provided;

3. Up-coding;

4. Unbundling;

5. Business, fiscal or medical practices which result in unnecessary costs to the programs operated by the DHCFP;

6. Duplicate billing for services, supplies or equipment;

7. Providing medical care, services or equipment which are not medically necessary or which fail to meet professionally recognized standards for health care; and/or

8. Failure to develop and maintain health service records as required by NRS 422.570 and DHCFP policy.

3. Confidentiality of information.

a. All material gathered during an inquiry of fraud, abuse or improper payment will only be used for the purpose for which it was gathered, and will not be distributed to any individual(s) or organization(s), with the exception of MFCU and/or the

Office of the Inspector General, the Centers for Medicare and Medicaid Services (CMS) or their sub-contractors.

b. Any information obtained by the DHCFP or the MFCU in an investigation of a provider of services under the State Plan for Medicaid is confidential unless it is used as evidence at a hearing to enforce the provisions of NRS 422.450 to 422.590 or to review an action by the DHCFP against a provider.

c. Release of information or evidence is done in compliance with published confidentiality and privacy law, rules and regulations. Materials collected by the DHCFP may be of an extremely sensitive nature. All such materials are kept secure.

d. The identity of any person reporting fraud, abuse or improper payments is not disclosed unless mandated by court order or the person agrees to the disclosure of their identity.

e. The identity of any recipient or applicant receiving assistance is always kept confidential unless disclosure is authorized by the recipient or legally responsible adult.

f. The DHCFP is a covered entity, as defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations (45 CFR Parts 160, 162 and 164), and as such, must comply with all aspects of this federal regulation.

3303.1B PROVIDER RESPONSIBILITY

1. Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers.

2. Providers must adhere to:

   a. DHCFP policy;

   b. Provider services and operations manuals;

   c. Fiscal agent billing manuals;

   d. All applicable federal law and state statutes; and

   e. Any other guidance furnished by the DHCFP or their fiscal agent regarding provider requirements and responsibilities.

3303.1C RECIPIENT RESPONSIBILITY

Recipients have an obligation to report to the DHCFP any suspicion of fraud, abuse or improper payment in DHCFP programs or concerning DHCFP recipients or providers.

3303.2 INVESTIGATIONS OF FRAUD, ABUSE OR IMPROPER PAYMENTS

The DHCFP conducts investigations of all suspected cases of fraud, abuse or improper payments. Investigations continue until an appropriate action is taken or the case is closed.

PERM reviews are done in accordance with the requirements mandated by CMS. PERM reviews are completed by CMS or their sub-contractors every three years starting in FY 2008.

Financial and Policy Compliance audits are performed regularly by the DHCFP and follow the standards and guidelines developed by CMS for the PERM reviews.

Suspected fraud or abuse discovered during the course of a PERM review or a Financial and Policy Compliance Audit will be referred to the MFCU for further investigation or action.

3303.2A COVERAGE AND LIMITATIONS

1. An investigation or review is initiated by the DHCFP when questionable practices are identified or the DHCFP receives complaints of suspected fraud, abuse or improper payments.

2. An investigation consists of a thorough review of the complaint or questionable practice and may include: An analysis of the paid claims; review of provider and recipient reports; review of policy and billing manuals; review of applicable rates; review of medical or other service record documentation; and review of appropriate federal law and state statutes.

3. The Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office is the single state agency responsible for the investigation and prosecution of violations of NRS 422.540 to 422.570, inclusive. (NRS 228.410) All suspected cases of provider fraud and/or abuse are referred to the MFCU in accordance with the MOU between the DHCFP and the MFCU.

4. PERM reviews consist of an analysis of randomly sampled Fee-For-Service (FFS) and managed care claims or line items.

   a. FFS claims or line items will undergo a medical record or service documentation review and a claims processing review.

1. At a minimum, the following items will be considered PERM Review Errors resulting from medical reviews:

    a. No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP.

    b. Claim billed with incorrect procedure code.

    c. Provider billed separate procedure codes when a bundled procedure code should have been used.

    d. The number of units billed was incorrect.

    e. Service was medically unnecessary.

    f. Service or procedure was not in agreement with documented policy.

2. At a minimum, the following items will be considered PERM Review Errors resulting from processing reviews:

    a. Duplicate claims billed for same service, same recipient and same date of service.

    b. Claim paid for a non-covered service.

    c. FFS claim paid although the recipient was enrolled in managed care.

    d. Incorrect rate was used to pay the claim.

    e. Logical edit issues (e.g. gender and procedure code are incompatible).

    f. Data entry errors.

b. Managed care payments will undergo a claims processing review only. The managed care claims reviewed will include monthly capitation payments and condition specific payments such as maternity payments and re-insurance payments. At a minimum the following items will be considered PERM Review Errors resulting from managed care reviews:

1. Recipient not eligible for enrollment in a Health Maintenance Organization (HMO).

2. Recipient not enrolled in the HMO that received the capitation or other payment.

3. Incorrect capitation or other payment – either the wrong rate cell was used to pay the claim or the rate was not consistent with the rate in the HMO contract.

5. Financial and Policy Compliance Audits may utilize random sampling techniques or may target specific provider types, procedures or services. These audits will utilize the guidelines for PERM reviews addressed in 4. of Section 3303.2A above.

3303.2B PROVIDER RESPONSIBILITY

1. Providers are bound by both federal and state statutes and regulations, DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.

2. DHCFP providers are required to keep records sufficient and necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to recipients. All services billed to and paid by the DHCFP which cannot be validated by appropriate documentation are subject to recovery.

3. Requested documentation must be provided within timeframes specified by the DHCFP or other state or federal officials.

4. Records, documentation and information must be available regarding any service for which payment has been or will be claimed to determine has or will be made in accordance with applicable federal and state requirements.

5. Providers must make all documentation requested by the DHCFP readily available for review by state and/or federal officials or their authorized agents. Readily available means the records shall be made available at the provider’s place of business or, upon written request, forwarded, without charge to the state or federal official requesting the documentation.

6. For medical record requests associated with DHCFP audits or investigations, providers are required to submit documentation to support the claims under review within 15 calendar days after receipt of a letter from the DHCFP requesting such information.

7. For medical record requests associated with the mandated federal PERM reviews, providers are required to submit documentation to support the claim or line item under review within the timeframes specified in the Payment Error Rate Measurement (PERM) Final Rule (released in the Federal Register on August 31, 2007) or any subsequent policy instruction issued by CMS.

8. All records subject to audit or review must be produced at no cost to the DHCFP.

9. Providers must adhere to both federal and state statutes and regulations and DHCFP policy concerning the appropriate and adequate documentation of services billed to the DHCFP.

10. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with DHCFP operations or services manuals and state and federal statutes and regulations.

11. Providers must retain patient records in accordance with state and or federal statutes and regulations or at a minimum for six years from the date of payment for the specified service.

3303.3 ADMINISTRATIVE ACTIONS AND CIVIL AND CRIMINAL PENALTIES

The DHCFP is required and authorized to review identified cases of suspected fraud, abuse and improper payments and impose appropriate actions upon offending parties. The DHCFP is able to impose a variety of Administrative Actions, including referral to the MFCU at the Attorney General's Office. The MFCU has the authority to impose civil monetary and other penalties as well as criminally prosecute offenders.

In determining the appropriate action(s) to recommend in a fraud, abuse or improper payment situation, the following will be considered:

1. Recommendations of the MFCU;

2. Action(s) necessary to eliminate fraud or abuse and to recover payments related to the fraud, abuse or improper payment;

3. Seriousness of the offense(s);

4. Number of current and past violations;

5. Provider's willingness to cooperate;

6. Past sanctions applied; and

7. Other available services in the area.

3303.3A COVERAGE AND LIMITATIONS

1. Administrative Actions. The DHCFP is authorized to take Administrative Actions to ensure compliance with program policies, state statutes and federal laws and regulations.

2. In response to the discovery of fraud, abuse or improper payments in the Medicaid and Nevada Check Up programs. The DHCFP may initiate more than one Administrative Action at one time, if warranted. (e.g. issuance of a recoupment/recovery letter and request a corrective action plan) The types of Administrative Actions that may be taken by the DHCFP are as follows:

   a. Issuance of educational letters. The DHCFP or the DHCFP fiscal agent may issue an educational letter to a provider if the results of an investigation indicate the provider was only in need of policy or billing clarification and an improper payment did not occur. This action is used primarily when minor billing errors are detected. The provider Fair Hearing process is not available to dispute an educational letter.

   b. Issuance of warning letters. The DHCFP may issue a warning letter to a provider if the provider has taken an action which violates or is not in accordance with policy, state statutes, federal laws or regulations, or the terms of the provider contract with the DHCFP. Warning letters will be sent by certified mail, with a return receipt requested. Warning letters are to assist the provider in rectifying improper billing practices and will give notice to the provider that continuation of the activity in question will result in further action. Warning letters may request submittal of sufficient and appropriate documentation to substantiate claims billed to and paid by the DHCFP. Failure of providers to submit appropriate documentation within timeframes specified by the DHCFP in a warning letter may result in payment recoupments/recovery without additional notice. The provider Fair Hearing process is not available to dispute a warning letter.

   c. Issuance of recoupment/recovery letters. The DHCFP may issue a recoupment/recovery letter to a provider if the results of an investigation indicate the provider was improperly paid for one or more services. A recoupment/recovery letter may also be sent after a provider fails to submit sufficient and appropriate documentation within the timeframes requested in a warning letter. Recoupment/recovery letters will be sent by certified mail, with a return receipt

requested. The letter will notify the provider of the nature of the improper payment, the amount to be recovered and the method of repayment. The provider Fair Hearing process is available to dispute recoupment/recovery letters unless the recoupment/recovery letter was the result of the provider's failure to provide sufficient and necessary information to establish medical necessity and to fully disclose the basis for the type, extent and level of services provided within the timeframes indicated in the letter that requested such information; or the provider's failure to provide sufficient and appropriate documentation within specified timeframes for the mandated federal PERM reviews.

d. Recovery of improper payments. The DHCFP may recover improper payments with or without prior notice to the provider. All improper payments discovered may be recovered by the DHCFP. If documentation sufficient to support the amount billed to or paid by the DHCFP is not provided within the timeframes specified by the DHCFP, the associated payments for the service are subject to recovery. All improper payments discovered during the course of mandated federal PERM reviews are subject to recovery.

e. Special claims reviews or on-site audits. The DHCFP can perform special claims reviews or on-site audits of any provider billing claims for Medicaid or Nevada Check Up programs. The reviews or audits can be conducted with or without prior notice to the provider under review. The provider Fair Hearing process is not available to dispute special claims reviews or on-site audits.

f. Corrective Action Plan. After the DHCFP conducts an investigation or audit and determines improper payments have been made, the DHCFP may require the provider to complete a Corrective Action Plan (CAP), specifying how, as well as when, the provider expects to achieve compliance. The provider Fair Hearing process is not available to dispute requests for Corrective Action Plans.

g. Provider self audits. The DHCFP may request a provider or group of providers to perform self audits. This action can be taken with or without the discovery of improper payments, or fraud or abusive billing practices. The DHCFP will accept reimbursement for improper payments, discovered during provider self audits, without penalty, if the improper payment was disclosed voluntarily by the provider and the acts that led to the improper payment were not the result of fraudulent conduct on the part of the provider, its employees or agents. Provider self audits do not relieve the provider of any liability for civil or criminal action by the MFCU, if improper payments were the result of fraud or fraudulent acts. The provider Fair Hearing process is not available to dispute requests for provider self audits.

h. Referrals to appropriate civil agencies (licensing bodies). If the DHCFP discovers licensing or other regulatory violations while conducting an investigation or audit,

the DHCFP may make referrals to appropriate licensing or governing entities, such as the Nevada Bureau of Licensure and Certification, the federal Office of the Inspector General, the federal Office of Civil Rights or other such governing entities. The provider Fair Hearing process is not available to dispute referrals to civil agencies or licensing bodies.

i. Referrals to the MFCU. The DHCFP is required to refer all suspected cases of fraud and abuse to the MFCU. Providers are never notified about this action.

j. Denials of provider applications. Providers may be denied DHCFP provider status if they are found to be out of compliance with policy, state and/or federal regulations or the terms of the provider contract with the DHCFP. Refer to Chapter 100 of the Medicaid Services Manual for further information.

k. Suspension and termination of provider status. Termination, lock-out suspension, exclusion, non-renewal of DHCFP provider status are possible actions applied to providers found to be out of compliance with policy, state and/or federal regulations, the terms of the provider contract with the DHCFP, or who commit fraud. Refer to Chapter 100 of the Medicaid Services Manual for further information.

l. Other action. The DHCFP may impose special requirements on providers as a condition of participation. Other actions include, but are not limited to:

1. Requirement for all services to be prior authorized to be eligible for reimbursement; and/or

2. Requirement for provider to submit all records or documentation to support the services billed prior to payment.

The provider Fair Hearing process is not available to dispute the other actions listed in l.1. and l. 2. above.

3. Any administrative action taken by the DHCFP does not eliminate any civil or criminal liability from the provider.

4. Withholding of payments to the provider. The DHCFP may withhold payments to the provider, in whole or in part, upon receipt of reliable evidence of fraud or willful misrepresentation under the Medicaid or Nevada Check Up programs. The DHCFP may withhold payment, without first notifying the provider. The DHCFP will send notice to the provider within five days of taking such action, in accordance with 42 CFR 455.23.

The notice to the provider will:

a. Specify the claims affected by the withholding action;

b. State that the withholding action will be for a temporary period;

c. Cite the circumstances under which withholding will be terminated.

d. Cite the duration of the withholding;

e. Inform the provider of the right to submit written evidence for consideration by the DHCFP; and

f. Cite that payments are being withheld in accordance with 42 CFR 455.23.

5. Repayment Requirements. The DHCFP will determine the repayment method for all overpayments or improper payments to providers. Repayment can be made by either direct reimbursement by the provider or the provider may be allowed to make repayment through deductions from future payments. To be acceptable, repayment through reductions to future payments or direct reimbursement must ensure the total overpayment amount will be repaid to the DHCFP within 60 days from the date the provider was first notified of the improper payment, as required by Section 1903 (d) (2) (c) of the SSA. The provider's request for a Fair Hearing does not suspend the provider's obligation to repay the amount of the overpayment.

6. Statute of Limitations. Erroneous billing resulting in a benefit overpayment violates the provider contract and brings the issue within the authority of NRS 11.190 Actions Other Than for the Recovery of Real Property. NRS 11.190.1 states: "Within 6 years: … 1(b) an action upon a contract, obligation or liability founded upon an instrument in writing, except those mentioned in the preceding sections of this chapter". This statute gives the DHCFP the authority that unless limited by a specific statute, a recovery action may be commenced within a six year period. Additionally, 31 USC 235-Limitation of Suit provides "Every such civil suit shall be commenced within six years from the commission of the act and not afterward."

7. Civil Monetary and Criminal Penalties

The Social Security Act (SSA) and the Nevada Revised Statutes (NRS) identify certain activities as misdemeanors or felonies and provide for fines and/or imprisonment upon conviction.

a. The Medicaid Fraud Control Unit (MFCU) of the Nevada Attorney General's Office can assess civil monetary penalties and criminally prosecute violations of

b. NRS 422.540 to 422.570, inclusive. This includes offenses regarding: false claims; mis-statements or mis-representations; and sale, purchase or lease of goods, service materials or supplies associated with payments under the State Plan for Medicaid or the State Children's Health Insurance Program (Nevada Check Up). Providers can be liable at both the state and federal level and prosecuted by both. Additionally, the provider may be excluded from state and federal health care programs based on a conviction.

c. State civil monetary penalties are not less than $5,000 and can equal three times the amount unlawfully obtained in addition to expenses incurred by the State for investigation activities.

d. State criminal penalties, in addition to the civil monetary penalties, range from a gross misdemeanor punishable by imprisonment in the county jail for not more than one year to a Class D felony punishable by 1-4 years in a State prison. (NRS 193.130 to 193.140)

e. In addition to State penalties, there are federal penalties associated with false or fraudulent acts involving federal health care programs. Civil monetary and criminal penalties are sought by the Department of Justice (DOJ) according to Section 1128A and Section 1128B of the SSA. Providers who are convicted by a federal court of willfully defrauding the Medicaid or Nevada Check Up program may be subject to a $25,000 fine or up to five years imprisonment or both.

f. Any action brought pursuant to NRS 422.540 through 422.580, inclusive, must be commenced within four years of discovery by the aggrieved party.

3304 REFERENCES AND CROSS REFERENCES

3304.1 FRAUD, ABUSE OR IMPROPER PAYMENT REFERRALS

1. To report alleged fraud, abuse or improper payment to the DHCFP contact:

   Phone: (775) 684-3648
   Fax: (775) 684-3643
   E-Mail: npi@dhcfp.nv.gov
   Mail: Division of Health Care Financing and Policy
   Program Integrity Unit
   1100 E. William St., Suite 102
   Carson City, NV 89701

   Provide as much identifying information as possible. Include: provider name, address, phone number and details regarding the allegation or nature of the referral. Explain the basics of who, what, when, where, why and how. Include your name and phone number unless you wish to remain anonymous when calling or writing.

   The DHCFP will not provide any information regarding actions taken by the DHCFP or others on any allegations reported, even to the person making the referral or allegation. Once the allegation is received, there will be no further communication with the person making the referral.

2. To Report Medicaid Fraud or Abuse to the Medicaid Fraud Unit in the Attorney's Office:

   Phone: 1-800-266-8688
   Mail: MFCU
   100 N Carson St.
   Carson city, Nv 89701-4717

3. To report fraud in all federal health care programs, including Medicare, Medicaid and Nevada Check Up contact the Office of Inspector General:

   Phone: 1-800-447-8477
   Fax: 1-800-223-8164
   TTY: 1-800-377-4950
   E-Mail: HHSTips@oig.hhs.gov
   By Mail: Office of the Inspector General, DHHS
   Attn: HOTLINE
   330 Independence Ave., SW
   Washington, DC 20201

The following is the link to the Office of Inspector General (OIG) Hotline website, where there is more information regarding how to make alleged fraud and abuse referrals: http://oig.hhs.gov/hotline.html

3304.2 POLICY REFERENCES

1. For policy information governing services covered under Medicaid and Nevada Check Up programs consult the Medicaid Services Manuals located on the DHCFP Website: http://www.dhcfp.nv.gov

2. For billing manuals, web announcements and other information governing services covered under Medicaid and Nevada Check Up programs consult the DHCFP fiscal agent Website: https://nevada.fhsc.com/

3304.3 OTHER CONTACTS

1. DHCFP Fiscal Agent

<u>Provider Enrollment Issues:</u>

First Health Services
Provider Enrollment
PO Box 300412
Reno NV 89520-30412

<u>Provider Claims Issues:</u>

First Health Services
Claims
PO Box 30042
Reno NV 89520-3042

2. <u>DHCFP Administration Office</u>

1100 E. Williams Street, Suite 102
Carson City, Nevada 89703
Telephone: (775) 684-3600
Toll free (800) 992-0900 extension 3600