## 37.19 MEDICAID FRAUD AND ABUSE

### Overview

Introduction

This section describes Medicaid provider and recipient fraud and abuse, its detection and penalties or correction, and the rights of the provider and recipient relative to abuse and fraud investigation.

**Note:** Providers should refer to Chapter 6 of the Medicaid Program Provider Manual for additional information on Program Integrity and Fraud and Abuse.

In This Section

This Section contains:

## 37.19.1 GENERAL

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, and the federal and state agencies have promulgated regulations and policies concerning fraud and abuse. It is the provider's responsibility to become familiar with these laws and regulations. This section will assist the provider in becoming familiar with the laws and regulations concerning fraud, abuse, and other incorrect practices. This section 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 if they violate laws, rules, regulations, or policies applicable to the Medicaid Program. Federal and state laws and regulations 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. They also stipulate as well as arranging for the prompt referral to the proper authorities for investigation or review to ascertain the facts without infringing on the legal rights of the individuals involved. These laws and regulations authorize the Department to conduct reviews of claims before and after they are paid in order to maintain the programmatic and fiscal integrity of the Medicaid Program.

In general, suspected criminal activities are investigated and prosecuted by the Medicaid Fraud Control Unit of the Attorney General's Office; civil actions are investigated and brought by the Department and/or the Attorney General's Office. Administrative actions are investigated and brought by the Department. Depending on whether the action is criminal, civil, or administrative, different standards of proof and levels of due process apply.

To report Medicaid fraud and/or abuse, contact Medicaid Program Integrity's hotline at 800-488-2917.

## 37.19.2 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 La. R.S. 14:67 and La. R.S. 14:70.01.

- 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; and
- 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 criminal conduct within federally funded programs. Refer to the applicable federal laws and regulations.

The lists below are not all inclusive but rather illustrative of practices which may be considered fraudulent activities and subject to criminal prosecution.

Provider Fraud

Examples of situations in which providers should be referred to the proper authorities for investigation include but are not limited to:

- Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid recipients;
- Billing for supplies or equipment that are unsuitable for the recipient 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;
- Materially misrepresenting dates and descriptions of services rendered, the identity of the provider or of the recipient;
- Duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.

Recipient Fraud

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

- The misrepresentation of facts in order to become or to remain eligible to receive Medicaid benefits or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;
- A recipient transferring 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 Medicaid Eligibility Card by persons not eligible to receive medical benefits under Medicaid.

## 37.19.3 ABUSE

Abuse and other incorrect practices by providers, recipients, and others include practices that are not criminal acts and may even be technically legal but still represent the inappropriate use of public funds. These acts are subject to sanctions.

Federal law also provides for civil remedies for abusive and incorrect practices. Refer to the applicable federal laws and regulations.

The lists below are not all-inclusive but rather illustrative of practices that are abusive or improper.

Provider Abuse

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

- The provision of services that are not medically necessary;
- Flagrant and persistent overuse of medical or paramedical services with little or no regard for the patient's medical condition or needs, or for the doctor's orders;
- The intentional 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 in order to gain a larger reimbursement than is entitled; and
- The solicitation or subsidization of anyone by paying or presenting any person 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.

Recipient Abuse

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

- Unnecessary or excessive use of the prescription medication benefits of the Medicaid Program;
- Unnecessary or excessive use of the physician benefits of the program; and
- Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.

## 37.19.4 CIVIL CAUSES OF ACTION

The Louisiana Medical Assistance Program Integrity Law (MAPIL) which is contained in La. R.S. 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. M APIL prohibits illegal remuneration, false claims, illegal acts regarding eligibility, and recipient lists among other things. These civil causes of action are set out in La. R.S. 46:438.1-46:438.5. Individuals, who are found by a court of law to have violated the provisions of MAPIL, are subject to triple damages, fines, cost, and fees.

**Note:** Refer to Section 37.2.2 Provider Rights and Responsibilities for detailed information.

## 37.19.5 FRAUD AND ABUSE DETECTION

Fraud and abuse are detected by several methodologies.

Referrals

Situations involving potential fraud and/or abuse which are to be followed up for review by Medicaid of Louisiana may include any or all of the following:

- Cases referred by the U.S. Department of Health and Human Services. Medicaid of Louisiana in turn refers suspected cases of fraud in the Medicare Program to the Centers for Medicare and Medicaid Services (CMS) and works closely with that agency in such matters;
- Situations brought to light by special review, internal controls, or provider audits or inspections; and/or
- Referrals from other agencies or sources of information.

Recipient Verification Notices (REOMBs)

The federal regulations (42 CFR 433.116(e) and (f)) for MMIS require that Medicaid of Louisiana provides prompt written notice of medical services which are covered to the recipients of these services. The information contained in the notice includes the name of the person(s) furnishing medical services, the date on which the services were furnished, and the amount of payment required for the services. A predetermined percentage of the recipients who have had medical services paid on their behalf during the previous month will receive the required notice, that is, the Recipient's Explanation of Medical Benefits (REOMB).

The REOMB contains the following information:

- The recipient's Medicaid identification number;
- The recipient's name;
- The date of the REOMB (monthly, on the 15th);
- The date of service for the services provided;
- A narrative description of the services provided;
- The place of service for the services provided;
- The provider of the services; and
- The amount paid for the services by Medicaid of Louisiana

On the reverse side of the REOMB, preprinted instructions request the recipients to use the space provided to call attention to any mistakes they feel were made on their bill. For example, if a service is listed on the REOMB that was not received by a recipient, or if the recipient was made to pay for a service that is covered by Medicaid of Louisiana, that recipient is expected to write a brief explanation of the error. The recipient should include his/her phone number and return the REOMB, postage paid, to the fiscal intermediary. The fiscal intermediary will then research the claim copy and provider remittance documents to make sure the recipient, provider, and services on the returned REOMB are accurately presented. If the information on the returned REOMB is not

accurate, the REOMB and all documentation will be reviewed by the Surveillance Utilization Review Subsystem (SURS) Unit.

All situations that require inquiry are reviewed by SURS. Situations that require criminal investigation are referred to the State Attorney General's Medicaid Fraud Control Unit.

Recipient Prescription Verification Letters

Prescription verification letters are sent to recipients in an effort to ensure that pharmacy services billed to Medicaid were received by the correct recipient and correctly billed. Each dispense date includes a picture of the actual drug(s) billed to Medicaid on the patient's behalf. The recipient is asked to make sure they received a drug on that date of service, that the drug they received looks like the drug in the picture, as well as confirm the amount of co-payment that they were asked to pay, if any. All exceptions are investigated.

Surveillance Utilization Review Subsystem (SURS)

The fiscal intermediary through its Surveillance Utilization Review Subsystem (SURS) can identify potential fraud and abuse situations by means of profile reports. A profile report is produced by a computer from information gathered in the state's claims payment operation. Providers are classified into peer groups according to geographic location, medical specialties and other categories.

Profile reports include the following information:

- A statistical profile of each peer group classification to be used as a base line for evaluation;
- A statistical profile of each individual provider compatible with the peer group profile;
- An evaluation of each individual provider profile against its appropriate group profile; and
- A listing of individual providers who deviate significantly from their group norm. (The individuals are reported as exceptional and are flagged for analysis.)

Each profile reported as exceptional is reviewed and analyzed by SURS staff and medical consultants. The analysis can include a review of the provider's paid claims, a review of the provider's reply to Medicaid of Louisiana's written request for information, a review of hospital charges and patient records, and a review of other relevant documents. The overall review is not necessarily limited to areas identified as exceptional on the profile report.

## 37.19.6 ADMINISTRATIVE ACTIONS/SANCTIONS

Federal laws and regulations and state laws provide the Department with the responsibility and authority to bring administrative actions against providers, recipients and others who engage in fraudulent, abusive and/or other incorrect practices. Sanctions which may be imposed through the administrative process include, but are not limited, to denial or revocation of enrollment, recommendation of revocation of licenses and/or certificates, withholding of payments, exclusion from the program, recovery of overpayments, and imposition of administrative fines.

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.

Definition

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

Grounds for Sanctioning Providers

Medicaid of Louisiana may impose sanctions against any provider of medical goods or services if it discovers that any of the following conditions occur:

- A provider is not complying with the Bureau'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 (La. 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;
- A provider has failed, after having received a written request from the Bureau, to keep or to make available for inspection or audit, copies of records regarding payments claimed 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 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.);
- The provider, or a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) five percent or more of the shares of

  stock or other evidences of ownership in a co rporation, 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, owner or person owning (directly or indirectly) five percent 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 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 or person owning (directly or indirectly) five percent 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 or 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.

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

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Levels of Sanctions

Examples of the different levels of administrative sanctions that Medicaid may impose against a Medicaid provider:

- Issue a warning to a provider through written notice or consultation;
- Require that the provider receive education in policies and billing procedures;
- Refer the provider to professional or quasi-professional boards or peer review organizations;
- Refer the provider to outside law enforcement agencies;
- Suspend the provider or withhold payments from the provider;
- Require that the provider terminate business association with an individual or entity;

- Limit the services that may be provided or the individuals to whom the services are provided;
- Recoupment;
- Recovery;
- Impose judicial interest on outstanding recoveries or recoupments;
- Exclude an individual or entity from participation;
- Require forfeiture of a posted bond;
- Impose an arrangement to repay;
- Impose withholding of payments;

- Withhold payments and recover money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
- Refer a provider to the appropriate state licensing authority for investigation;
- Impose fines and costs;
- Impose bonds or other forms of security; and
- Payment may be suspended to any provider who fails to meet the requirements for participation in the Medicaid Program for any other authorized reason.

**Note:** This list is not all-inclusive. The provider should refer to the laws and regulations related to Medicaid participation.

## 37.19.7 APPEALS

The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Department's Bureau of Appeals is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained from the Bureau of Appeals at the following address:

**DHH Bureau of Appeals**
**Post Office Box 4183**
**Baton Rouge, LA. 70821-41822**
**Phone 225-342-0263 or Fax 225-342-0443**