



## CHAPTER 800(B)—QUALITY AND PROGRAM INTEGRITY CHANGE LOG

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## CHAPTER 800(B) – QUALITY AND PROGRAM INTEGRITY

### INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

### 800.1 DEFINITIONS

Definitions governing the policies described in this chapter will apply pursuant to Common Chapter 200, Acronyms and Definitions, of the Provider Manual. In addition, the following definitions also apply to this chapter.

**Abuse** - Actions that are inconsistent with acceptable business or medical practice

**Civil Fraud** - To knowingly submit, or cause to be submitted, a false, fictitious, or fraudulent claim for reimbursement. This could be performed by deliberate ignorance or reckless disregard of the truth related to the claim. Civil fraud is determined by a “preponderance of the evidence” standard. Penalties for civil fraud may include fines up to three times the amount of damages sustained by the government as a result of the false claims.

**Criminal Fraud** - To intentionally and knowingly submit, or cause to be submitted, a false, fictitious, or fraudulent claim for reimbursement. Criminal fraud is determined by a “beyond a reasonable doubt” standard. Penalties for criminal fraud may include fines, imprisonment, or both.

**Decision Support System (DSS)** - A computer system designed to provide assistance in determining and evaluating alternative courses of action. A DSS (1) acquires data from the mass of routine transactions of a business, (2) analyzes it with advanced statistical techniques to extract meaningful information, and (3) narrows down the range of choices by applying rules based on decision theory. Its objective is facilitation of 'what if' analyses and not replacement of human judgment.

**Exception Report** - A listing of abnormal or excessive services that fall outside of accepted norms based upon established medical standards/principles.



**Exception Profiling** - A process that compares activity for a statistical measurement against a norm for that statistic

**Good Cause Exception** - An exception to permit a suspected fraudulent provider to continue to provide services to Medicaid members for reasons as specified in Title 42 Code of Federal Regulations (CFR) Section 455.23

**Medicaid Integrity Group (MIG)** - Contractors engaged by the Centers for Medicare & Medicaid Services (CMS) to audit claims for payment for items or services under a State Plan, which identify overpayments to individuals or entities receiving Federal funds.

**Partial Suspension of Payment** - The process in which a provider may only receive a portion of the reimbursement for services rendered. This may occur when the suspected fraud is not believed to be system-wide throughout the provider. A partial suspension of payment may occur due to suspected fraud occurring with a specific service or product, a rendering practitioner, or another reason that may not incorporate the provider's entire reimbursement.

**Payment Error Rate Measurement (PERM)** - A program developed by CMS to estimate the amount of improper payments to Medicaid providers, submit those estimates to Congress, and report on actions CMS is taking to reduce the improper payments.

**Recovery Audit Contractor (RAC)** – A contractor West Virginia Medicaid is required by Title 42 CFR Part 455 to maintain in order to aid in Program Integrity activities.

**Self-audit** - A process when a review of provider records is conducted by the provider themselves

**Spike Report** - A report that recounts a sharp rise in the frequency for a given variable, usually immediately followed by a decrease

**Suspension of Payment** - A process wherein the Medicaid reimbursement to a provider is stopped

**Trend Analysis** - The method of collecting data in order to determine a pattern in the information

**Waste** - Over-utilization of services or the misuse of resources provided for which medical necessity is not present

## **800.2 PROGRAM DESCRIPTION**

The Office of Quality and Program Integrity (OQPI) was formed in July 1995, as the result of funding by the West Virginia Legislature, to monitor the utilization of Medicaid Services.

The OQPI is charged with meeting the requirements set forth in:

- Title 42 CFR Section 455.1 Program Integrity: Medicaid – Requirements for a State fraud detection and investigation program and



- Title 42 CFR Section 456.1, Utilization Control – Requirements concerning control of the utilization of Medicaid services

Title 42 CFR Section 455.13 states, “The Medicaid agency must have—

- (a) Methods and criteria for identifying suspected fraud cases;
- (b) Methods for investigating these cases that—
  - (1) Do not infringe on the legal rights of persons involved; and
  - (2) Afford due process of law; and
- (c) Procedures developed in cooperation with State legal authorities for referring suspected fraud cases to law enforcement officials.”

The OQPI executes the federal requirement of Title 42 CFR Section 456.3 which states, “The Medicaid agency must implement a statewide surveillance and utilization control program that—

- (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
- (b) Assesses the quality of those services;
- (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
- (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.”

The OQPI conducts post-payment reviews. OQPI is responsible for identifying fraud, waste, and abuse cases and uses a combination of processes and claims data systems to complete this task. The processes and claims data systems detect fraud, waste, and abuse by reviewing member and provider information including, but not limited to:

- Claims submitted for services not rendered
- Claims submitted for services that do not meet medical necessity
- Upcoding or unbundling of services
- Documentation does not support services billed
- Services violating Federal and/or State policy, procedures, and/or regulations
- Services used excessively
- Services received with another’s Medicaid card
- Services received by the member falsifying their eligibility for a medical card or information to receive medical treatment
- Services received from the physician in order to abuse/misuse prescription drugs
- Services by or under contract with an enrolled provider who has been excluded or disqualified from participation and receipt of monies from a Federal program

### **800.3 QUALITY AND PROGRAM INTEGRITY FUNCTIONS**

Quality and Program Integrity oversight includes:



- 1) Data Analysis and Review
- 2) Post Payment Review
- 3) Prevention versus Collection
- 4) Medicaid Fraud Referrals
- 5) Provider Eligibility

These functions are discussed in the following sections.

### **800.3.1 DATA ANALYSIS AND REVIEW**

Data analysis and review includes analysis of management information summaries, maintenance of OQPI case files, comprehensive/limited audits, trend analysis, establishment of norms, identification of providers outside of norms, and identification of providers requiring closer examination.

Sources used in identifying providers for review include:

- Exception reports,
- Trend analysis,
- Utilization analysis,
- Spike reports,
- Participant/provider/staff complaints, and
- Referral from internal and/or external sources.

Exception profiling may be utilized as the first step for case development in detecting or controlling fraud and abuse. However, it is generally combined with information from either a data warehouse or decision support system due to the format of query results.

Once data is analyzed, a review process is designed based upon the specifics of the issue.

Reviews may identify overpayment for recoupment and underpayments. Reviews often reveal the need for OQPI to make recommendations to develop, update, and/or clarify BMS policy.

### **800.3.2 POST PAYMENT REVIEW**

OQPI performs post payment review of claims to ensure:

- Conformance to Federal and West Virginia Medicaid rules and regulations;
- Medical necessity and appropriateness;
- Payment to an enrolled and qualified provider on behalf of an enrolled member; and
- Units and services billed match units and services documented in the providers' records.

These reviews provide a means to identify and measure fraud and abuse. Post-payment reviews are conducted on Medicaid providers and members by utilizing computer software programs/systems. These systems are used to review provider utilization by generating profiles of health care providers and members in comparison with their peers. Post payment review analyzes frequency, standard



deviations, outliers, spike reports, etc., in order to identify potential overpayments, questionable billing practices, and/or fraud, waste, and abuse.

Post payment review may include a provider site audit to evaluate records in their totality or records may be requested for submission to OQPI. Other reviews may be completed by BMS or their designee.

### **800.3.3 PREVENTION VERSUS COLLECTION**

It is more efficient to prevent improper payments than to discover them after they transpire; therefore:

- OQPI focuses on ensuring there are review systems and controls in place to prevent improper payments. OQPI determines what improvements are necessary to claims payment systems and claims edit/controls to prevent improper payments.
- OQPI staff reviews policy chapters and makes recommendations to the policy committee members after identifying any potential weaknesses within the program policy.
- OQPI makes recommendations for service limits, billing codes, and edits to reduce improper payments from occurring.

### **800.3.4 MEDICAID FRAUD REFERRALS**

OQPI is charged with investigating complaints and identifying potential fraud, waste, and abuse occurring within the Medicaid system. Complaints are received from various sources for development, investigation, and appropriate resolution.

OQPI investigates each case to determine if there is a credible allegation of fraud, waste, or abuse. If it is a credible allegation of fraud, waste, or abuse, the complaint is referred to the West Virginia Office of the Inspector General Medicaid Fraud Control Unit (MFCU). The provider is also subject to payment suspension, absent good cause exception as noted in Section 6402(h)(2) of the Affordable Care Act. If OQPI or their contracted agent suspects that a member or patient at a facility has been abused or neglected, a referral is made to MFCU.

MFCU has jurisdiction under federal and state law to investigate West Virginia Medicaid providers for potential fraudulent practices, and the authority to seek criminal and civil remedies when fraudulent practices are discovered.

Complaints regarding **member** fraud should be referred to the **West Virginia Office of the Inspector General Investigations and Fraud Management Unit**. The process of reporting member fraud can be found at <https://www.wvdhhr.org/oig/mfcu/secRepFrd/>.

### **800.3.5 PROVIDER ELIGIBILITY**

The OQPI partners with various state and federal agencies and provider associations, some of which





include the Department of Health and Human Services, the BMS fiscal agent, internal program staff and the provider community to ensure compliance with provider eligibility requirements.

### **800.3.5.1 PROVIDER SCREENING**

The OQPI reviews for compliance with Title 42 CFR Part 1007 relating to requirements for provider screening. This includes reviews of initial provider applications as well as random reviews of enrolled providers to ensure applications are current and reflect any substantive changes outlined in the regulations and ensure all required disclosure information is present. OQPI may review employees/contractors of the enrolled provider to determine provider compliance with required checks of public databases identifying any individuals/entities that have been excluded or disqualified via criminal conviction/license revocation or restriction from providing or being reimbursed for services paid by any federal/state program. OQPI reviews personnel records of enrolled providers' employees providing direct care or having direct access to Medicaid members to ensure there are no disqualifying criminal convictions that would prohibit these individuals from providing services. A description of these disqualifying offenses may be found in the appropriate chapter of the BMS provider manual or within applicable federal and state regulations. If upon review it is found such an individual has been employed, monies are recovered for any services provided by the individual/provider.

### **800.3.5.2 EXCLUSIONS**

The OQPI supports other state and federal program exclusions as mandated under federal law and regulations. Program exclusions have the effect of prohibiting reimbursement by WV Medicaid for services provided by the excluded individual whether employed by or under contract with an enrolled provider. This broad prohibition applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or prospective payment systems. Furthermore, it should be recognized that an exclusion remains in effect until the individual or entity has been reinstated to participate in Federal health care programs in accordance with the procedures set forth in Title 42 CFR 1001.3001 through 1001.3005. Reinstatement does not occur automatically at the end of a term of exclusion, but rather an excluded party must apply for reinstatement. If the state initiates such exclusion, an appeal process will be afforded to the individual in accordance with existing policy. If however, such exclusion is already in place and published, the only appeal right would be based upon incorrect identity. Providers' right of appeal is described in West Virginia Medicaid Manual Chapter 300 (Chapter 300).

### **800.3.5.3 CRIMINAL INVESTIGATIVE BACKGROUND CHECKS**

The OQPI will work to ensure compliance with applicable federal and state policy/regulations to ensure such checks are conducted and that no individual with a disqualifying offense provides services to Medicaid beneficiaries. If upon review it is found such disqualifying offenses exist, monies will be recovered for any services provided by the individual/provider from the date of disqualification. While the WV Medicaid program's goal is to remain current on all federal/state regulations regarding criminal background checks. It is the responsibility of the provider to determine appropriate methods for routing review of their employees/contractors to ensure compliance with current law.



## **800.4 IDENTIFICATION OF CASES**

BMS is mandated under federal law to provide methods and procedures to review utilization and payment for care and services provided under the state plan. BMS must safeguard against unnecessary utilization of care and services. Payments are made with efficiency, economy, and quality of care considerations. BMS ensures there are sufficient providers so that care and services under the state plan are available to the general population of West Virginia.

### **800.4.1 METHODS USED TO IDENTIFY ISSUES AND/OR CASES**

OQPI cases originate from a variety of sources.

- 1) Referrals – Referrals are received from many sources and come in varying degrees of completeness. Referrals are made by members, providers, BMS staff, West Virginia DHHR staff, the MFCU, and others.
- 2) Case Finding – Cases can also be identified by use of outlier reports utilizing resources which may include but are not limited to: Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); Current Dental Terminology (CDT); Medicare DRG Definitions Manual; Medicare Correct Coding Guide; and applicable pharmacy standards or research of manuals to identify qualifiers to services such as service limits, mutually exclusive codes, services which should be provided in a bundled rate, or services limited to certain eligibility groups.
- 3) Data Analysis System Process – The process that takes each claim submitted and sorts the claim data into computerized reports.

The data analysis system is a tool that is frequently used to research information for the other two methods of case identification such as the following:

- Compare like member and provider groups resulting in Exception Reports which identify Medicaid members whose utilization of services is aberrant when compared to members of similar age and health. These reports also identify providers whose practice patterns are aberrant when compared to their peer group.
- Identify increases or decreases in provider activity over time resulting in Spike Reports. These reports can be generated across all categories of providers and at an individual level, and are focused to identify the appropriateness of a drug or procedure. Produced on an as-needed basis, Spike Reports are accompanied by documentation identifying the issues which cause the provider/member to be identified as an exception.

When referrals are received by OQPI, specific queries can be run on the data analysis system with specific parameters focused on the suspected fraud or abuse.

## **800.5 INVESTIGATING COMPLAINTS**

Complaints come to the OQPI through many different sources, e.g., the Inspector General's Hotline, MFCU, telephone referrals, letters, program staff, other State or Federal agencies, etc.



The initial investigation may result in a determination of the following:

- 1) No outstanding issue, which results in case closure;
- 2) A potential fraud issue, which results in MFCU referral; and/or
- 3) An overpayment issue, which results in OQPI review

## **800.6 UTILIZATION REVIEW ACTIVITIES**

Utilization review activities may be performed by requesting documentation of services being submitted for review to OQPI, or may be conducted at the provider's location. Medicaid members sign a release of information as part of the application process; therefore, no additional release of information is required for providers to make records available for review. Failure to comply with a request for records or request for a self-audit may result in a hold on all Medicaid payments until the requested documentation is received.

Records may be selected using generally accepted and approved sampling techniques. An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period that services were reviewed (i.e., all claims billed in one month, quarter, year, etc.).

When the BMS has identified unnecessary and/or inappropriate practices through monitoring activity or other reviews, it may pursue one or more of the following actions which may include (but is not limited to):

- 1) Recoupment of inappropriately paid monies
- 2) Requirement of a satisfactory written plan of correction
- 3) Limited participation in the Medicaid program that may include:
  - a) Prior authorization for all services;
  - b) Prepayment review of all applicable claims;
  - c) Suspension of payment until a plan of correction is filed and accepted;
  - d) Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
  - e) Ban on specific services based upon review findings.
- 4) Exclusion from participation in the West Virginia Medicaid Program through the following actions:
  - a) Suspension;
  - b) Disenrollment;
  - c) Denial, non-renewal, or termination of provider agreements.
- 5) Referral to MFCU
- 6) Withholding of payment involving fraud or willful misrepresentation.
- 7) Referral to the provider's licensing and/or certifying body(ies) for appropriate action based upon the licensing and/or certifying body(ies) regulations.

The recoupments of overpayments are handled as defined in Chapter 300. When a written plan of correction is required, the provider must create and submit the plan to BMS within the time specified in



the notice. The plan shall address all deficiencies noted in the review report and identify steps to correct deficiencies and establish time lines for successful implementation of the corrective action plan. The plan is subject to the approval of BMS. If the case is under the jurisdiction of a court, the court may have authority to approve or disprove the plan for overpayment.

In cases of limited participation, as noted above, BMS will notify the provider in writing regarding the limitation placed on participation, the duration of the limitation, and the corrective action necessary to remove the restriction. In cases of prohibition from participation, BMS will notify the provider in writing in advance as to the reasons for the action and the effective date and duration.

Providers' right of appeal is described in Chapter 300.

If a provider's fiscal agent/billing company requests a copy of a letter sent from OQPI to the provider, the fiscal agent/billing company will be required to send a copy of the billing service agreement that exists between the provider and the fiscal agent/billing company before the letter will be sent. Before a copy of an OQPI letter can be sent, there must be verification of the identity of the prospective recipient.

#### **800.6.1 ON-SITE REVIEW**

On-site review refers to a review of provider records conducted by OQPI staff or contractor at the provider location(s). The review may be announced or unannounced.

When an onsite review is conducted, the provider will make available a work area which provides some privacy and guarantees the confidentiality of the records during the review process. The cost of making necessary copies to validate appropriate utilization is included in provider reimbursement for Medicaid procedures.

An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period services were reviewed (i.e., all claims billed in one month, quarter, year, etc.). A draft report will be issued to the provider detailing the possible issues and amounts that might be disallowed. The draft report contains a time period in which the provider may respond with documentation in order to justify the disputed services.

When, in the opinion of OQPI, the provider's response to the draft report justifies the services disputed, there may be either a modification or no disallowance of services. OQPI will then compose a letter informing the provider there was a modification or no disallowance and the case is closed.

When, in the opinion of OQPI, the provider's response to the draft report **DOES NOT** justify all of the services disputed, OQPI will issue a Final Report with the case's final disposition and amount of disallowance. The final report details the provider's rights of appeal.

#### **800.6.2 DESK REVIEW**

Desk review refers to the instance when a review of provider records is conducted by OQPI staff at BMS. There are generally two types of Desk Review:

- 1) Compliance Reviews – This type of review includes, but is not limited to, a review of policy requirements, such as exceeding established service limits, or identifying claims that were paid



to an ineligible population. Requests for records from the provider are not generally required to complete this review process. The provider will receive a “Demand Letter” that details the reasons for service disallowance. They are then expected to reimburse BMS for all disallowed services. The demand letter details the provider’s rights of appeal.

- 2) Documentation Reviews - In this type of review, a sample of records is requested from the provider and reviewed by staff to determine whether the service was billed and paid in accordance with the appropriate program regulation(s) or policies(s). An error percentage may be calculated from the sample results and extrapolated across all claims billed during the period services were reviewed (i.e., all claims billed in one month, quarter, year, etc.).

Documents requested for a review by OQPI may be sent by the provider as electronic or paper copies.

The outcomes of the documentation reviews are the same as an on-site review.

### **800.6.3 SELF-AUDIT/SELF-DISCLOSURE**

Health care providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of State and Federal resources. If a provider suspects improper billing in an attempt to defraud WV Medicaid, or an ongoing fraud scheme within its organization, it should immediately contact BMS’ OQPI. If a provider performs a self-disclosed self-audit, the interest will not be imposed to the reimbursement amount unless the provider’s payments are not made on the BMS specified payment dates.

OQPI may request that a provider perform a self-audit as a result of a specific area of questionable billing.

When a self-audit is assigned, a self-audit letter is sent to the provider. The self-audit letter details the format in which the provider is to report their findings along with their options of repayment.

### **800.6.4 INFORMATIONAL REVIEW**

OQPI may conduct a review to gather program data and/or additional information used for program administration. This type of review is for informational purposes only, and does not result in a monetary disallowance. It may, however, lead to further investigation.

### **800.7 RECOUPMENT PROCESS**

This procedure outlines the recoupment process for OQPI within BMS.

When a provider receives a Demand Letter/Final Report from OQPI, they have 30 days to enter into a repayment agreement and an additional 30 days to effectuate payment if they enter into a repayment agreement. Additional information is included in the Demand Letter/Final Report.



Providers have three basic repayment options from which to select. They are as follows:

- 1) Check remittance within 60 days of receipt of notification
- 2) Placement of a lien against further Medicaid payments so that recovery is effectuated within 60 days after notification of the overpayment.
- 3) A recovery schedule in which the provider may make payments for up to 12 months. The payment amount and due dates are determined by BMS, and the provider is notified of the repayment schedule. .

If determined by the BMS fiscal unit, providers may be instructed to perform reversal/replacement instead of the repayment options listed above.

### **800.8 DOCUMENT/DESK REVIEW PROCESS**

A Document/Desk Review is the first level of appeal available to West Virginia Medicaid providers. A request for a Document/Desk Review must be made to the Commissioner of the Bureau for Medical Services. Additional information on the Document/Desk Review Process may be found in Chapter 300.

- 1) When a provider enters into a repayment agreement, they retain their rights of appeal.
- 2) Document/Desk review decisions ordering the provider to refund the overpayment will become effective within five days from the date of the decision, or within 60 days from the date of the original disallowance notification, whichever is later. Interest will accrue on any portion remaining after the 60 day notification period.
- 3) If the overpayment determination is reversed by the Document/Desk review, BMS will refund any previous payments made by the provider down to the disallowance amount determined in the Document/Desk review.
- 4) Upon learning of a decision from the Document/Desk review favoring BMS, the method of repayment chosen by the provider will take effect in five days. Recoupment will begin at this time even if the provider requests an evidentiary hearing.
- 5) If the provider did not enter into a repayment agreement with BMS, a lien will be requested by OQPI five days from the date of the provider's receipt of the Document/Desk review decision, or within 60 days from the date of the provider's receipt of the demand letter/final report, whichever is later.
- 6) If the provider fails to adhere to the method of repayment chosen by them on the repayment agreement, BMS will recoup the remainder of the overpayment as well as any accumulated interest.
- 7) If the overpayment determination is reversed by an evidentiary hearing, BMS will refund any previous payments made by the provider down to the disallowance amount determined in the evidentiary hearing.

### **800.9 MEDICAID FRAUD AND ABUSE**

Both fraud and abuse have the same impact: they detract valuable resources that would otherwise be used to provide care to Medicaid beneficiaries.



- A) It is mandated in 42 CFR Section 456.3, “The Medicaid agency must implement a Statewide utilization program that...
- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; and
  - Assesses the quality of those services.”
- B) Title 42 CFR Section 455.13 states, “The Medicaid agency must have...
- Methods and criteria for identifying suspected fraud cases; and
  - Methods for investigating these cases.”

When fraud is suspected, a preliminary investigation will be performed by OQPI. After review of the data, and consultation with appropriate staff, a decision will be made as to whether a referral to MFCU is warranted.

#### **800.10 SUSPENSION OF PAYMENT**

A suspension of payment to a provider shall be performed when there is a credible allegation of fraud. When OQPI determines a suspension of payment is in order, the following steps will be taken:

- OQPI will determine if good cause exception exists to not suspend payment.
- A fraud referral to MFCU will be effected.
- The supervising attorney of BMS’ Legal Department will be informed of the intent to suspend payment.
  - \* Within five business days, either MFCU or BMS’ Legal Department must recommend to the OQPI Office Director for good cause exception if there is good cause not to suspend payment, or to suspend only in part. If either recommends a good cause exception, the suspension will not be placed at that time or a partial suspension will be placed.
- Five business days after the fraud referral is placed with MFCU, a notice of intent to suspend shall be sent to the provider. Their rights of appeal will be contained in the letter. The suspension will commence 30 days from receipt of the letter.

A suspension may be placed immediately if OQPI or MFCU have reason to believe the provider will cease or seriously curtail operations prior to recovery of the overpayment.

A suspension will be removed when:

- There are methods in place to recoup the entire fraudulent overpayment, or
- It is determined by OQPI and MFCU that there is no credible evidence of fraud

#### **800.10.1 SUSPENSION OF PAYMENT APPEAL PROCEDURES**

An appeal process is available to West Virginia Medicaid providers when a provider is notified of intent to suspend payment.



- Written evidence of the reason payment should not be suspended must be received by the Commissioner of BMS within five business days after receipt of the notice of intent to suspend. Upon review of submitted evidence, BMS will inform the provider whether the suspension is affirmed or reversed.
- If, after review of the provider submitted evidence, BMS affirms the suspension of payment, the provider may request an evidentiary hearing. This request for an evidentiary hearing must be received by the Commissioner of BMS within 30 calendar days of the provider's receipt of the affirmation of the suspension of payment. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2 Request for Evidentiary Hearing.
- If a provider refuses or fails to submit written evidence within the specified time period, they shall have 30 calendar days from receipt of the notice of intent to suspend in which to request an evidentiary hearing. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2 Request for Evidentiary Hearing.

## **800.11 OQPI RESPONSIBILITIES TO CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)**

OQPI is responsible for ensuring that all BMS Program Integrity activities are in compliance with Federal Medicaid regulations. As such, OQPI is required to coordinate its Program Integrity activities with various CMS oversight entities. Among these responsibilities are providing CMS with working details of BMS' Program Integrity activities, coordinating any CMS audits of West Virginia Medicaid providers, overseeing Recovery Audit Contractor (RAC) audits, and cooperating with CMS in periodic audits of BMS program integrity reviews.

### **800.11.1 MEDICAID INTEGRITY GROUP (MIG)**

In accordance with the Deficit Reduction Act (DRA) of 2005, CMS is obligated to engage contractors (referred to by CMS as Audit Medicaid Integrity Contractors, or "Audit MICs") to audit claims for payment for items or services under a State Plan, and identify overpayments to individuals or entities receiving Federal funds. CMS' Medicaid Integrity Group (CMS-MIG) has engaged in a number of outreach activities to educate States about the activities it is conducting pursuant to the Medicaid Integrity Program (MIP), and about issues such as the manner in which subjects for audits under the program will be chosen, and how the overpayments identified in the course of Medicaid Integrity Program audits will be collected.

OQPI has been charged with the responsibility to deal directly with CMS-MIG and its Audit MICs in order to efficiently and accurately aid in CMS' conducting of audits of West Virginia Medicaid providers. Effective communication with CMS-MIG will minimize duplication of efforts and mitigate conflicts with the provider community. In order to facilitate those ends, the State Medicaid agency (OQPI) is responsible for:

- 1) Reviewing/vetting audit leads;
- 2) Reviewing draft audit reports provided by CMS-MIG;
- 3) Participating in various communications efforts with the Audit MIC;





- 4) Providing the Audit MIC with information regarding applicable State and Federal laws, regulations, policies, and provider contact information for audit subjects; and
- 5) Complying with any requirements determined by CMS-MIG to be necessary for carrying out MIC audits, pursuant to Section 1902(a)(69) of the Social Security Act, in accordance with its Medicaid State Plan Amendment regarding the Medicaid Integrity Program.

#### **800.11.2 RECOVERY AUDIT CONTRACTOR (RAC)**

As required by Title 42 CFR Part 455, West Virginia Medicaid is required to maintain a RAC to aid in Program Integrity activities. Within BMS, OQPI is charged with the responsibility to oversee all RAC activities. OQPI staff will coordinate audit activities with the RAC, provide support and validation of data review/analysis, and review all completed audits performed by the RAC prior to their release to ensure the reliability of its conclusions and adherence to all West Virginia Medicaid regulations and policies.

#### **800.11.3 PAYMENT ERROR RATE MEASUREMENT (PERM)**

The Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) requires the heads of Federal agencies to regularly review programs they administer and identify those that may be susceptible to significant improper payments, to estimate the amount of improper payments, to submit those estimates to Congress, and to submit a report on actions the agency is taking to reduce the improper payments. The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with the IPIA and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.

OQPI is responsible for assisting CMS in conducting their PERM reviews of WV Medicaid providers and ensuring that they run as efficiently as possible. In order to meet these responsibilities OQPI will:

- 1) Provide CMS with all requested data from its medical payments system (MMIS);
- 2) Assist CMS in educating WV Medicaid providers about PERM requirements;
- 3) Aid CMS in ensuring WV Medicaid providers respond to records requests within stated time frames;
- 4) Educating CMS about specific WV Medicaid policies and regulations;
- 5) Evaluate any PERM error decisions affecting WV Medicaid providers to ensure accuracy;
- 6) Recover dollars identified as errors from the provider; and
- 7) Complete a Corrective Action Plan (if necessary) to address any payment error deficiencies identified by PERM.

#### **800.11.4 FEDERAL OFFICE OF THE INSPECTOR GENERAL (OIG) AUDITS**

It is the responsibility of OQPI to assist the Federal Health and Human Services OIG with any audits/reviews they undertake regarding WV Medicaid providers. The Office of Evaluation and



Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.

## **800.12 FEDERAL FALSE CLAIMS REQUIREMENT**

Section 6032 of the Deficit Reduction Act of 2005 (DRA) requires that any provider who meets a threshold of \$5 million in net Medicaid reimbursement during the Federal fiscal year (October 1 through September 30 of the following year) must establish and maintain written policies which provide detailed information about the Federal laws imposing civil and criminal penalties for submitting false Medicaid claims. In addition, the provider must have written policies and procedures to detect and prevent fraud, waste and abuse in Federal health care programs, i.e. Medicaid. A copy of these policies must be provided to all of its employees, contractors, and agents. These policies must include an explanation of the False Claims act; the entity's policies and procedures for detecting and preventing waste, fraud, and abuse; the rights of employees to be protected as whistle blowers; and telephone numbers and/or addresses for reporting fraud and abuse.

To ensure compliance with the DRA, OQPI will annually request copies of required information (electronic or paper) for providers meeting the \$5 million threshold, and conduct desk reviews of providers' written policies, procedures, and employee handbooks as they relate to the requirements of the DRA.

OQPI will provide written response of approval or denial of the entity's policies along with any suggestions to ensure they conform to the requirements of the DRA. Thereafter, OQPI will conduct a review of affected entities who continue to meet the \$5 million threshold on a yearly basis for any updates or changes to its written policies. In addition, BMS may also review the entity's DRA policies during any regular on-site review of Medicaid billings.