WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

# CHAPTER 800 PROGRAM INTEGRITY

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## BACKGROUND

The Office of Program Integrity (OPI) was formed in July 1995, as the result of funding by the West Virginia Legislature, to monitor the utilization of Medicaid Services. The OPI is charged with meeting the requirements set forth in:

- Title 42 CFR, Section 455 Program Integrity: Medicaid – Requirements for a State fraud detection and investigation program, and
- Title 42 CFR Section 456 Utilization Control – Requirements concerning control of the utilization of Medicaid services.

Title 42 CFR Section 455.13 states, "The Medicaid agency must have:"

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

The OPI 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:"

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

## POLICY

The OPI conducts post-payment reviews. The OPI is responsible for identifying potential 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 potential 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 a practitioner for member abuse/misuse of prescription drugs; and

- Services by or under contract with an enrolled provider who has been excluded or disqualified from participation and received monies from a federal program.

## 800.1 OPI RESPONSIBILITIES TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES

OPI is responsible for ensuring that all Bureau for Medical Services (BMS) program integrity activities are in compliance with federal Medicaid regulations. As such, OPI is required to coordinate its program integrity activities with various Centers for Medicare and Medicaid Services (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.

### 800.1.1 Unified Program Integrity Contractors (UPICs)

In accordance with the Deficit Reduction Act (DRA) of 2005, CMS is obligated to engage contractors (referred to by CMS as Unified Program Integrity Contractors (UPICs)) to audit claims for payment for items or services under a State Plan and identify overpayments to individuals or entities receiving Federal funds. The UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPICs perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice, Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.

The OPI has been charged with the responsibility to work directly with the CMS-assigned UPIC to aid in CMS' audits of West Virginia Medicaid providers. Effective communication with the UPIC will minimize duplication of efforts and mitigate conflicts with the provider community. To facilitate those ends, the State Medicaid agency (OPI) is responsible for:

- Reviewing/vetting audit leads.
- Reviewing draft audit reports provided by the UPIC.
- Participating in various communications efforts with the UPIC.
- Providing the UPIC with information regarding applicable State and Federal laws, regulations, policies, and provider contact information for audit subjects; and
- Complying with any requirements determined by the UPIC to be necessary for carrying out UPIC 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.

### 800.1.2 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, OPI is charged with the responsibility to oversee all RAC activities. OPI 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.

### 800.1.3 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 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.

OPI is responsible for assisting CMS in coordinating their PERM reviews of West Virginia Medicaid providers and ensuring that they run as efficiently as possible. To meet these responsibilities OPI will:

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

## 800.2 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), OFFICE OF THE INSPECTOR GENERAL (OIG) AUDITS

It is the responsibility of OPI to assist the DHHS OIG with any audits/reviews they undertake regarding West Virginia Medicaid providers. The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide DHHS, 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 DHHS programs. OEI reports also present practical recommendations for improving program operations.

## 800.3 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 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 fraud, waste and abuse; the rights of employees to be protected as whistleblowers; and telephone numbers and/or addresses for reporting fraud and abuse.

To ensure compliance with the DRA, OPI 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.

OPI 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, OPI 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.

## 800.4 FRAUD, WASTE AND ABUSE

Fraud, waste and abuse have the same impact: All three detract valuable resources that would otherwise be used to cover care for Medicaid beneficiaries.

- 42 CFR, Section 456.3 mandates "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."

- 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 OPI. After review of the data, and consultation with appropriate staff, a decision will be made as to whether a referral, as a Credible Allegation of Fraud (CAF), to the West Virginia Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) is warranted. This process is discussed in *Section 800.5.4, Investigating Referrals to OPI*.

## 800.5 PROGRAM INTEGRITY FUNCTIONS

Program integrity oversight includes:

- Data analysis and review;
- Pre- and post-payment review;
- Prevention versus Collection;
- Investigating referrals to OPI;
- Provider eligibility;
- Coordination of external audits and recoveries
- Oversight of Medicaid Managed Care Special Investigation Unit (SIU) activities; and
- Referrals to the Medicaid Fraud Control Unit (MFCU).

These functions are discussed in the following sections.

## 800.5.1 Data Analysis and Review

Data analysis and review includes analysis of MMIS summaries, maintenance of the OPI case files, limited/comprehensive 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, waste, 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 any issue(s) identified.

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

## 800.5.2 Pre- and Post-Payment Review

The OPI performs pre- and 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, waste, and abuse. Pre-payment reviews may include flagging certain procedure codes, types of claims, etc. for manual review prior to adjudication by the BMS fiscal agent. Pre-payment reviews are time-sensitive based on claims processing requirements.

Post-payment reviews are conducted on Medicaid providers and members by utilizing computer software programs/systems. These systems generate profiles of health care providers and member services, including comparison with their peers. Post-payment review analyzes frequency, standard deviations, outliers, spike reports, etc., to identify potential overpayments, questionable billing practices, and/or fraud, waste, and abuse. BMS and its participating managed care organizations (MCOs) will leverage post-payment reviews only where a substantiated basis of known or suspected waste, fraud or abuse by a provider exists.

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

## 800.5.3 Prevention Versus Collection

It is more efficient to prevent improper payments than to discover improper payments after the payments have transpired; therefore:

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

The OPI maintains policies and procedures to ensure that the CMS Medicaid National Correct Coding Initiative (NCCI) is implemented within the Medicaid claims processing system. The NCCI promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicaid claims. The NCCI coding standards, recommended by CMS and compiled by the American Medical Association (AMA), apply to Current Procedural Terminology (CPT) numeric codes and the Healthcare Common Procedure Coding System (HCPCS) alpha-numeric codes. Providers must use the most current CPT, HCPCS, and ICD manuals applicable to the date of service when billing for services provided to Medicaid members. The CMS Medicaid NCCI website provides links to the NCCI edits, methodologies and reference documents, such as policy and technical guidance manuals.

Provider claims may also be subject to coding standards developed by BMS and/or required under the contract with its fiscal agent.

## 800.5.4 Investigating Referrals to OPI

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

Referrals regarding possible member or provider fraud are received by the OPI from many different sources, e.g., members, providers, the West Virginia Department of Health and Human Resources (DHHR) Office of Inspector General's Hotline, MFCU, telephone referrals, letters, program staff, other State or Federal agencies, etc. As much information as possible is gathered during the initial receipt of the referral.

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

- A referral that must be forwarded to a different state agency;
- No outstanding issue, which results in OPI case closure;
- An overpayment issue, which results in OPI review; and/or
- A potential fraud issue, which results in MFCU referral.

The OPI investigates each case to determine if there is potential waste, abuse, or a credible allegation of fraud (CAF). If a CAF exists, the case is referred to the MFCU. In addition, if OPI or their contracted agent suspects that a member, resident, or patient at a facility has been abused or neglected, a referral is made to MFCU. See § 800.5.8, Referrals to Medicaid Fraud Control Unit.

Referrals regarding potential **member** fraud are referred to the **West Virginia DHHR Office of the Inspector General's Investigations and Fraud Management Unit**. The process for reporting possible member fraud can be found at the West Virginia OIG website.

## 800.5.5 Provider Eligibility

The OPI partners with various state and federal agencies and provider associations, some of which include the DHHS, the BMS fiscal agent, internal program staff and the provider community to ensure compliance with provider eligibility requirements.

### *800.5.5.1 Provider Screening*

The OPI reviews provider applications to ensure the state's 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 the most recent applications on file for enrolled providers, to ensure any substantive changes outlined in the regulations have been made and all required disclosure information is present. The OPI may also review the personnel records of provider employees/contractors to determine provider compliance with required screenings of public databases.

Providers must review publicly available databases at least monthly to identify any individuals/entities that have been disqualified or excluded via criminal conviction/license revocation or restricted from providing/being reimbursed for services paid by any federal/state program. Publicly available databases include but are not limited to the OIG's List of Excluded Individuals (LEIE), the West Virginia Medicaid list of providers terminated/excluded for cause, and the websites of healthcare licensing entities. If, upon review, an ineligible individual is found to have been employed, monies are recovered for any services provided by the individual/provider. A description of disqualifying offenses may be found in the applicable federal and state regulations and/or the BMS policy manual.

### *800.5.5.2 Provider Sanctions and Exclusions*

The OPI supports state and federal provider exclusion requirements as mandated under federal law and regulations. Provider exclusions have the effect of prohibiting reimbursement by West Virginia Medicaid for services provided by an excluded individual, regardless of whether the excluded individual is the enrolled provider, an employee, or a contractor. This broad prohibition applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or prospective payment systems. Federal exclusion of an individual or entity remains in effect until the excluded individual or entity successfully petitions for reinstatement 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 federal exclusion, but rather an excluded party must apply for reinstatement.

If the state initiates an exclusion, the exclusionary period may extend beyond that of the Federally mandated exclusionary period. An appeal process will be afforded to the individual subject to a state

exclusion in accordance with existing policy. A provider's right to appeal rejection of enrollment is described in the West Virginia Medicaid Policy Manual, *Chapter 300, Provider Participation Requirements.*

### *800.5.5.3 Provider Operational Deficiencies*

The OPI will monitor and act on findings, such as operational deficiencies, related to provider enrollment and long-term care enrollment in accordance with Federal and State regulations. For example, a recertification review of a facility by the West Virginia Office of Hospital and Facility Licensure (OHFLAC) that reveals operational deficiencies may result in OPI action on a provider's enrollment. In addition, monies will be recovered for any services provided by the individual/provider from the date of enrollment disqualification. Please refer to *Chapter 300, Provider Participation Requirements*. and applicable BMS Policy Manual chapters for specific provider service requirements.

## 800.5.6 Coordination of External Audits And Recoveries

The OPI coordinates external audits and recoveries of overpayments identified by BMS-contracted entities, such as the federally required Recovery Audit Contractor. The OPI also participates in partnership with state agencies and universities to monitor and audit Medicaid claims and complete recoveries, as appropriate. For example, the OPI has a long-standing relationship with another state agency in the post-payment review of Home and Community-Based Services (HCBS) potentially disallowed as a result of the audits carried out by that agency. OPI then coordinates the recovery of any Medicaid overpayment that results from a final HCBS disposition letter.

## 800.5.7 Oversight of Medicaid Managed Care Organizations' Special Investigative Units (SIUs)

Program Integrity requirements specific to Medicaid MCOs are outlined in 42 CFR 438.600. Participating MCOs must have administrative and management policies and procedures designed to detect and deter fraud, waste, and abuse. MCOs must establish and maintain a Special Investigations Unit (SIU) to investigate potential FWA and BMS requires MCOs to notify the OPI of all such incidents. The MCO and its SIU must work with the BMS, MFCU, and CMS to administer effective prevention, detection, and resolution of fraud, waste and abuse.

Participating MCOs are required to cooperate with the BMS when payment suspensions are imposed by OPI. When the BMS sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the identified provider within one business day. If the MCO does not suspend payments to the provider, the BMS may pursue further remedies as allowed for by the Service Provider Agreement.

As the MCOs are responsible for detecting fraud, waste and abuse in claims they paid, they retain the sole right to recover overpayments during a BMS-determined reasonable grace period following the date a claim was paid. However, through the BMS/MCO Managed Care Service Provider Agreement, BMS has retained the right to review managed care claims and retain any overpayments first identified by the State, following the MCO grace period. In addition, Medicaid funds misspent due to fraud, waste, and abuse actions by the MCO, or its Subcontractors will be subject to recovery by the State and may result in further remedies as allowed for by the Managed Care Service Provider Agreement.

### 800.5.8 Referrals to the Medicaid Fraud Control Unit (MFCU)

The 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.

The provider(s) in the referred case is/are also subject to payment suspension, absent good cause exception as noted in Title 42 CFR Section 455.23.

Referrals regarding potential provider fraud must be detailed on OPI's Fraud Referral Form located on the West Virginia Medicaid OPI webpage. The completed form must be submitted to the following email address: DHHRBMSMedicaidOPI@wv.gov

Cases referred to MFCU are tracked by the OPI within its case management system. MFCU may accept or decline the referral from the OPI. Cases accepted by MFCU are documented as such and are closed in the OPI case management system upon final disposition of the case. For cases declined by MFCU, BMS may opt to refer the case to other law enforcement agencies.

## 800.6 IDENTIFICATION OF CASES FOR OPI REVIEW

BMS is mandated under federal law to establish methods for review of utilization and payment for care and services provided under the State Plan and to safeguard against unnecessary utilization and/or inappropriate payment for these activities.

### 800.6.1 Methods Used to Identify Cases

The OPI cases originate from a variety of sources, including but not limited to:

- Referrals – Referrals are received from many sources and come in varying degrees of completeness. Referrals are made by members, providers, BMS staff, DHHR staff, the MFCU, and others.
- Data Analytics – Data mining using algorithms that sort claims data for further review. Examples of data analysis include:
    - Comparison of similar member and provider groups to identify Medicaid members whose utilization of services is aberrant when compared to members of similar age and health.
    - Identification of 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 provider level and are focused on identifying the appropriateness of a drug, service, supply, or procedure.
    - Outlier Reports – Routine and ad hoc reports are used to identify potential cases for review utilizing resources which may include but are not limited to: CPT; HCPCS; Current Dental Terminology (CDT); Medicare Diagnosis-related Groups (DRGs); and the National Correct Coding Initiative Policy and Manuals. Standards, such as those developed by healthcare insurers, national health care and provider organizations, and healthcare compliance consultants may also be used to identify qualifiers for services, such as appropriate service limits, mutually exclusive codes, services which should be provided in a bundled rate, or services limited to certain eligibility groups.

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

## 800.7 PROVIDER 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 self-audit reveals overpayments, the provider shall disclose the specifics to OPI via the self-audit/self-disclosure process outlined on the BMS website.

OPI may request that a provider perform a self-audit regarding 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.

A provider should immediately contact OPI at (304) 558-1700 or via email at DHHRBMSMedicaidOPI@wv.gov, if they suspect an organization or individual of improper billing intended to defraud West Virginia Medicaid or identifies an ongoing fraud scheme.

## 800.8 OPI UTILIZATION REVIEW ACTIVITIES

Utilization review activities may be performed by OPI through a desk review of provider documentation, submitted upon request by OPI, or conducted at the provider's location, i.e., an on-site review. OPI uses a variety of sampling techniques, such as claims identified by a specific code, random sampling, statistical sampling, etc. West Virginia 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. Provider failure to comply with a request for records or request for self-audit may result in the suspension of all Medicaid payments until the requested documentation is received.

When West Virginia Medicaid has identified unnecessary and/or inappropriate practices through monitoring activity or other reviews, the agency may pursue, but is not limited to, the following actions:

- Recoupment of inappropriately paid monies, as defined in Section 800.10, Recoupment Process.
- Requirement of a written CAP deemed satisfactory by BMS.
- Limited participation in the Medicaid program that may include:
    - Prepayment review of all applicable claims;
    - Suspension of payment until a plan of correction is filed and accepted;
    - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
    - Ban on specific services based upon review findings; and/or
    - Prior Authorization for all Medicaid services.
- Exclusion from participation in the West Virginia Medicaid Program through one or more of the following actions:
    - Suspension
    - Disenrollment, or
    - Denial, non-renewal, or termination of provider agreements.
- Referral to MFCU;
- Withholding of payment involving fraud or willful misrepresentation; and/or

- Referral to the provider's licensing and/or certifying body(ies) for appropriate action based upon the licensing and/or certifying body(ies) regulations.

In cases where the provider's participation in West Virginia Medicaid is limited, 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.

If a provider's fiscal agent/billing company/attorney requests a copy of a letter sent to the provider by the OPI, the fiscal agent/billing company will be required to send, to OPI, a copy of the billing service agreement that exists between the provider and the fiscal agent/billing company. If the service agreement is unavailable, other verification of the identity of the requestor will be required before the letter will be provided. Upon receipt of the required documentation, the OPI will send the fiscal agent/billing company a copy of the provider's letter.

When a written CAP is required, the provider must create and submit it to BMS within the time specified in the OPI notice. The CAP shall address all deficiencies noted in the review report, identify steps to correct deficiencies and establish timelines for its successful implementation. The submitted CAP is subject to approval by BMS. If the case is under the jurisdiction of a court, the court may have authority to approve or disapprove the CAP. Failure to submit a written CAP may result in a suspension of payment.

## 800.8.1 Informational Review

OPI 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 which could result in a monetary disallowance.

## 800.8.2 Desk Review

Desk review refers to the instance when a review of provider records is conducted by OPI staff at BMS.

There are generally two types of Desk Review completed by the OPI:

- Compliance Reviews – This type of review includes, but is not limited to, a review of claims based on policy requirements, such as services exceeding established service limits or paid for an ineligible population. Medical records are not generally required to complete this review process. The OPI staff review claim reports and identify overpayments.
- 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 policy(ies). Documents requested for a review by OPI may be sent by the provider as electronic or paper copies.

Both types of desk review will result in the provider receiving a "Demand Letter" that details the reasons for service disallowance and the provider's rights of appeal. The provider is expected to reimburse BMS for all disallowed services. See Section 800.10, Recoupment Process.

If the provider wishes to contest any of the findings in the Demand Letter, they must first request

"Reconsideration." See Section 800.11.1, Provider Request for Reconsideration.

### 800.8.3 On-Site Review

On-site review refers to a review of provider records conducted by the OPI staff and/or a BMS or CMS contractor at the provider location(s). The review may be announced or unannounced and may occur over a few hours to several days.

When an on-site review is carried out, the provider will make available a work area which provides privacy and guarantees the confidentiality of the records during the review process. The number of medical records to be reviewed may be based on a sample of claims or may be an expanded review of medical records previously provided to the OPI. The cost of making copies of documentation needed to validate appropriate utilization is included in provider reimbursement for Medicaid services. The review will begin with an entrance interview composed of the review team and provider staff. The entrance interview will detail the services under review and define the parameters of the review.

At the conclusion of the on-site review, an exit interview with the provider will be completed by the review team. No findings will be released at that time.

A draft report will be issued by the OPI to the provider detailing the on-site review findings and potential amounts to be disallowed. The draft report will contain a timeframe in which the provider may respond with documentation necessary for reconsideration. Please see Section 800.11.1, Provider Request for Reconsideration.

## 800.9 SUSPENSION OF PAYMENT

A suspension of payment to a provider shall be performed when there is an indictment at the federal or state level or a credible allegation of fraud. When OPI determines a suspension of payment is in order, the following steps will be taken:

- OPI will determine if good cause exception exists to not suspend payment.
- Lead Counsel of BMS' Legal Department will be informed of the intent to suspend payment.
- Within five business days OPI refers to BMS' Legal Department for good cause exception if there is good cause not to suspend payment, or to suspend only in part. If OPI recommends a good cause exception, the suspension will not be placed at that time or a partial suspension will be placed. MFCU can request a law enforcement exception from OPI.
- Five business days after the fraud referral is placed with MFCU, a notice of suspension shall be sent to the provider. Their rights of appeal will be contained in the letter. The suspension will commence on the date of the letter.

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

A provider may submit written evidence of the reason payment should not be suspended to the BMS Legal Department 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 appeal See Section, 800.11, Appeal Process.

A suspension will be removed when:

- The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
- Legal proceedings related to the provider's alleged fraud are completed.

## 800.10 RECOUPMENT PROCESS

Recoupment of disallowances may be based on a specific amount identified for the claims included in the review/audit or the amount to be recovered may be based on extrapolation. Extrapolation is the use of statistical sampling for an audit with estimation of overpayments based on a predetermined percentage of disallowance applied to a universe of claims. West Virginia Medicaid follows CMS guidance on the use of extrapolation.

When a provider receives finalized findings from OPI or one of its auditing vendors, they have 30 days to enter into a repayment agreement, followed by an additional 30 days to effectuate payment of the disallowance. Providers can choose one of the three repayment options listed below:

- Check remittance for the full amount of the disallowance within 60 days of receipt of repayment date notification;
- Placement of a lien against future Medicaid payments so that recovery is effectuated within 60 days after notification of the overpayment; or
- A repayment schedule in which the provider may make payments for up to 12 months, either by check or monthly deduction from future claims. The payment amount and due dates are determined by BMS, and the provider is notified in writing of the repayment schedule.

If a provider enters a repayment agreement, they retain the rights of appeal. If the provider does not choose a repayment option within the allotted timeframe, a lien will be placed on future payment until the full disallowance is recovered.

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

## 800.11 APPEAL PROCESS

Provider appeal rights related to a disallowance include specific requirements and timeframes. It is important for the provider to respond to findings in a timely manner to retain rights to each appeal level.

If a provider wishes to appeal the findings of a review, they cannot skip any appeal level and begin with a higher appeal level. When a provider disagrees with a review finding they must seek a first level appeal by requesting reconsideration of initial audit findings (see Section 800.11.1, Provider Request for Reconsideration). Providers who do not seek reconsideration of the initial review findings will be understood to have accepted the results of the review and will be ineligible to seek a document desk review (see Section 800.11.2, Provider Request for Document/Desk Review) or evidentiary hearing (see Section 800.11.3, Evidentiary Hearing Process). Extension requests will be considered when submitted no fewer than five business days prior the due date.

## 800.11.1 Provider Request for Reconsideration (RFR)

- Providers may submit a request for reconsideration in response to the initial findings issued by OPI or its audit vendor. Findings are not considered final until 30 days after receipt of the draft findings letter or upon completion of any request for reconsideration that was granted. The RFR must be submitted in writing within 30 days from the provider receipt of the initial review findings and must include the policy basis for the proposed corrections and service documentation to support the appeal. The proposed corrections must be claim specific.

**A first level appeal without supportive documentation OR beyond 30 days of receipt of the OPI initial review findings will not be considered.**

The RFR must be mailed to "Attn: OPI Director – Request for Reconsideration" at the address listed on the initial findings letter or emailed to DHHRBMProviderappeals@wv.gov with "Attn: OPI Director – Request for Reconsideration" in the Subject line or the address provided by the auditing vendor.

When the provider's RFR justifies the reimbursement of services in question, there may be either modification to or reversal of disallowed services. The OPI will then issue a letter informing the provider of the modification or reversal and an updated findings report. If all the previously disallowed services are reversed, there is no disallowance, and the case is closed.

When the provider's RFR **DOES NOT** justify reimbursement of all the services in question, the OPI will issue finalized findings with the review's final disposition and amount of disallowance. The finalized report details the provider's rights to further appeals and the standard recoupment process (§800.10). Recoupment of the disallowed amount will begin within 30 days of issuance of the finalized findings and will continue during any further appeal that may be requested.

**To retain the right to the second appeal level, a Document/Desk Review (DDR), a provider must complete the full BMS first level appeal process.** as stated above in this section.

## 800.11.2 Provider Request for Document/Desk Review (DDR)

A DDR is the second level appeal to BMS, and a request must be received within 30 days of provider receipt of the finalized review findings for the first level appeal. Second level appeals requests received beyond the 30 days will not be considered.

A second level appeal must include a copy of the BMS finalized review findings redetermination decision, a completed "Appeal Request Form" and documentation to support the DDR request. Second level appeals requested without each of the requirements listed above OR beyond 30 days of the date of the finalized findings will not be considered.

DDR determinations are expected to be issued to the provider within 60 calendar days from the date BMS receives the completed Appeal Request Form seeking a document desk review. If, due to the complexities of a DDR, BMS' Office of Legal Services is unable to release the findings of a DDR within 60 days from the date BMS receives the completed Appeal Request Form seeking a document desk review, The BMS Office of Legal Services will issue a letter notifying the provider of the expected date the DDR findings will be released.

If the overpayment determination is reversed by the DDR decision, BMS will refund any previous payments made by the provider. In the event that a claim under DDR review is found to have been underpaid, BMS will issue a payment to the provider for the underpaid amount.

A second level appeal must be mailed and addressed to:

Bureau for Medical Services
Office of Program Integrity – Provider Appeals
350 Capitol Street, Room 251
Charleston, WV 25301

Or by email: DHHRBMSproviderappeals@wv.gov

Decisions on DDR requests are made by BMS legal counsel based upon the documentation submitted with the appeal.

## 800.11.3 Evidentiary Hearing Process

The final level of appeal is an evidentiary hearing. An evidentiary hearing is a formal hearing procedure before the Commissioner of BMS or his/her designee. Only issues reviewed in the preceding document desk review and set forth in written request for Evidentiary Hearing will be considered.

The request for an evidentiary hearing must be in writing, dated, signed, and received within 30 days of receipt of decision from the document/desk review. The request for an evidentiary hearing shall contain a statement as to the specific issues or findings of fact and/or conclusions of law in the preceding determination with which the provider disagrees and basis for its contention that the specific issues and/or findings and conclusions were incorrect. The request must include identification of the provider representatives who will be present at the hearing. The parties will be permitted only 2 continuances. Any provider requesting a hearing resulting from an adverse decision of BMS shall bear the necessary and attendant costs of such hearing, including costs of transcription, court reporting, production and copying of documents and all similar costs. If a factfinder or hearing examiner should be retained by BMS, the costs of said factfinder or hearing examiner shall be borne by BMS.

A complete record of proceedings at the hearing shall be made and transcribed in all cases.

BMS will issue a written decision based on findings of fact and conclusions of law, setting forth reasons for the decision as soon as practical after the hearing. The decision by the Commissioner of BMS or designee is final. The provider may pursue further recourse through judicial review.

## 800.12 APPEAL PROCESS OVERVIEW

### Step 1

0 to 30 days following provider receipt of initial findings

**Findings Contested**

- Providers disagreeing in whole or part with the initial findings must respond to the initial findings with a request for reconsideration.
- The request for reconsideration must include a factual basis and service records demonstrating identified claims were paid in compliance with all relevant billing requirements.

**Findings Accepted**

- Initial findings are accepted, and the provider must submit a completed repayment agreement to West Virginia Bureau for Medical Services (BMS).

### Step 2

30 to 60 days following provider receipt of initial findings

**Findings Contested**

- Final report issued to provider reflecting any modifications resulting from reconsideration.
- Providers that disagree with the finalized findings must submit a completed Audit Appeal Request Form seeking a DDR and completed repayment agreement.
- Recoupment of the identified overpayments will begin upon receipt of the completed repayment agreement or 60 days following provider receipt of the final report if no repayment agreement submitted.

**Findings Accepted**

- Providers accepting the finalized findings must submit a completed repayment agreement. If no repayment agreement is received by the BMS, a lien is placed on the provider's account for the disallowance amount of 60 days following provider receipt of the final report.

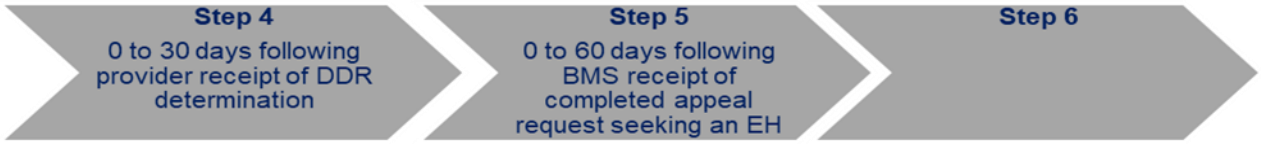
### Step 3

0 to 60 days following BMS receipt of a completed appeal request seeking a DDR

- Office of Legal Services completed requested DDR and issues a determination to the provider and the OPI.
- BMS returns to the provider any payments collected during the appeal process which were determined through the DDR to have been paid appropriately.

**Complex Appeal Cases**

- Office of Legal Services will issue a notice to the provider advising them that their appeal remains in a pending status and indicates an expected completion date.




- Providers that disagree with the DDR determination must submit a completed appeal request form seeking an Evidentiary Hearing (EH).

### Findings Accepted

- Provider accepts the DDR determination reached by the Office of Legal Services and continues repayment of the overpayments identified.

- Office of Legal Services completed the requested EH and issues a determination to the provider and the OPI.
- BMS returns to the provider any payments collected during the appeal process, which were determined through the EH to be paid appropriately.

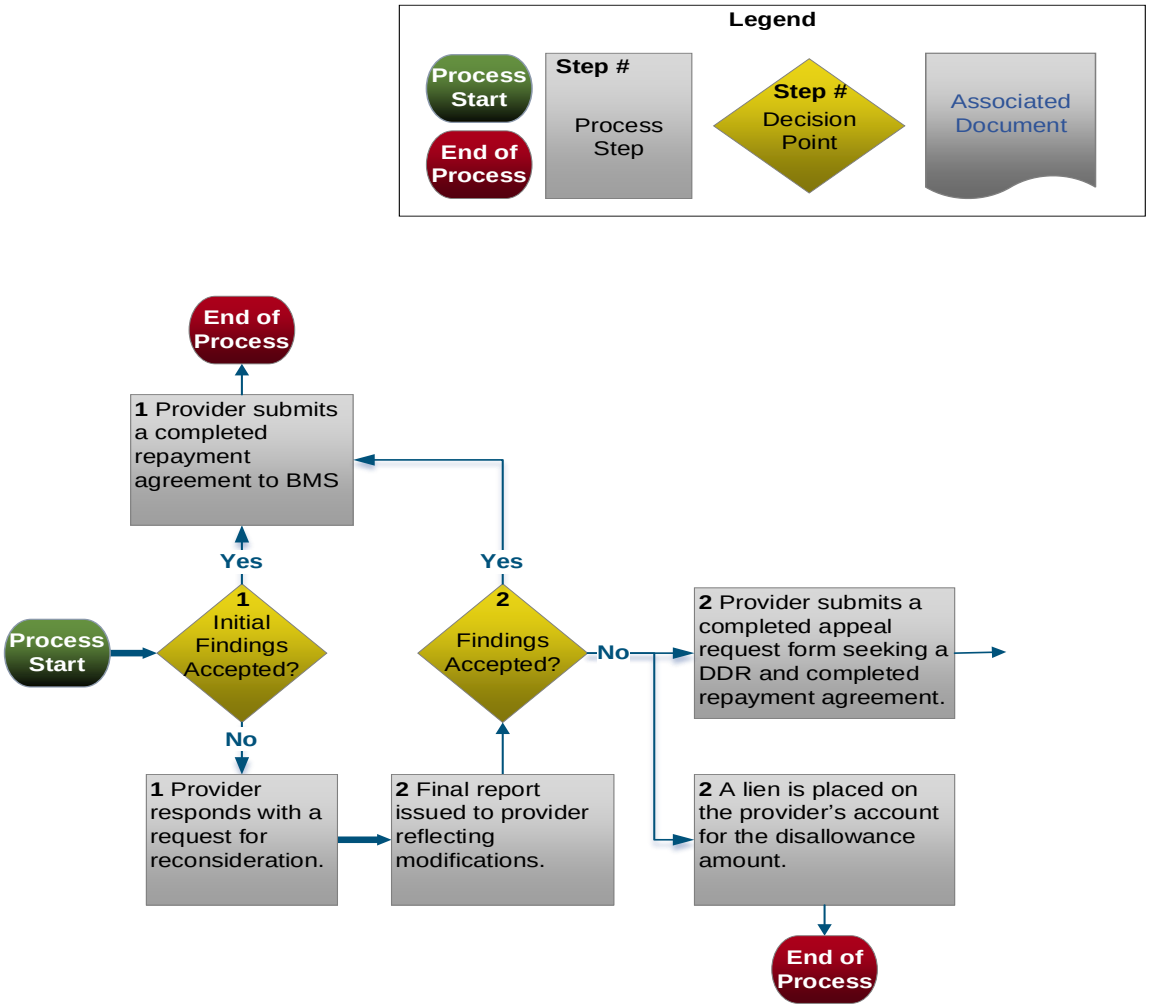
### Complex Appeal Cases

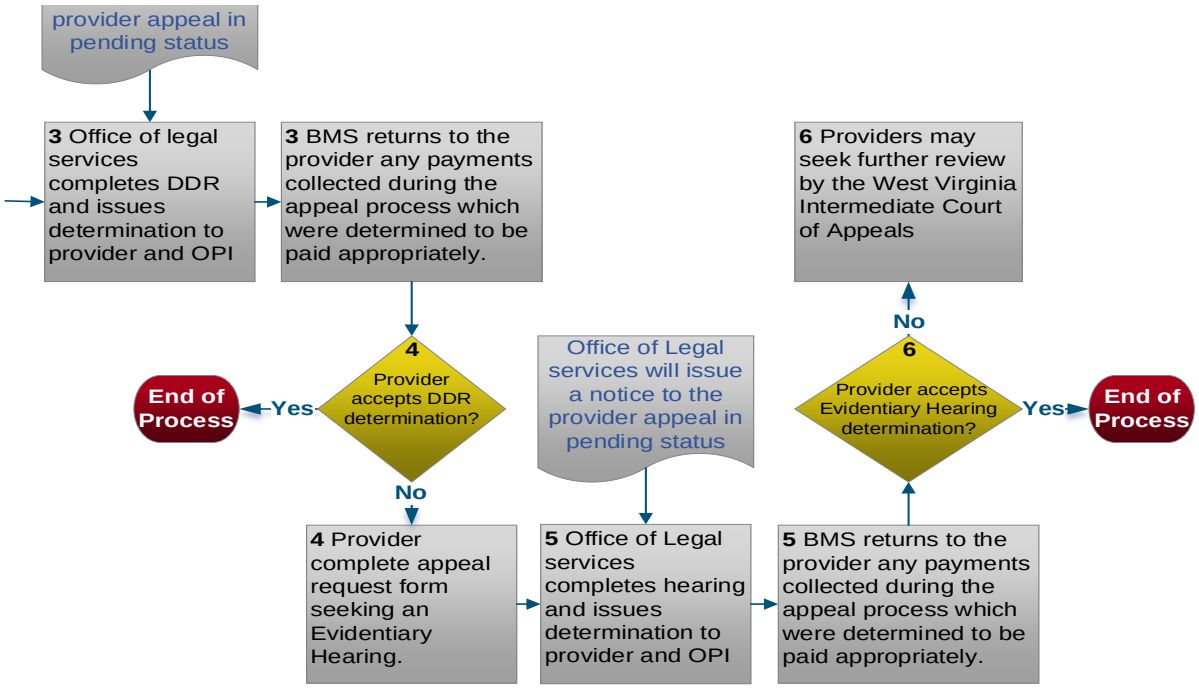
- Office of Legal Services will issue a notice to the provider advising them that their appeal remains in a pending status and indicates an expected completion date.

- Providers that disagree with the EH determination may seek further review by the West Virginia Intermediate Court of Appeals.

### Findings Accepted

- Provider accepts the EH determination reached by the Office of Legal Services and continues repayment of the overpayments identified.






## GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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

**Credible Allegation of Fraud (CAF):** An allegation that has been verified by a State and that has indicia of reliability that comes from any source.

**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.

**Fraud:** The intentional misrepresentation of services rendered in order to increase reimbursement.

**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.

**Operational Deficiencies:** Deficiencies identified by or reported to the BMS which constitute a breach of the WV Medicaid Provider Manual or state or federal law.

**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 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.

**Supportive Documentation:** Service documentation or citations to relevant authorities considered by the provider to be supportive of the appropriateness of the payments deemed by BMS to be overpaid.

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

**Trend Analysis:** The method of collecting data 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.

## *CHANGE LOG*

| REPLACE | TITLE | EFFECTIVE DATE |
|---|---|---|
| Entire Chapter | Reorganized Program Integrity Requirements from Chapter 800 (B) and into the ADDED Chapter 800<br>Updated office title to Office of Program Integrity (OPI)<br>Updated citations and other references<br><br>800.1 Added - OPI responsibilities to CMS<br>800.1.1 Added - Unified Program Integrity Contractor (UPIC) functions<br>800.5.6 Added - Coordination of external audits<br>800.5.7 Added - Managed Care Oversight<br>800.3.3 to 800.7 Modified – Provider Self-Audit<br>800.10.1 to 800.11 Modified - appeal process<br>800.7 to 800.10 Modified - recoupment process<br>800.11 Added - appeal process overview<br>800.11.1 Removed - Medicaid Integrity Group (MIG)<br>Glossary Updated Definitions | August 1, 2023 |