Title 23: Division of Medicaid

Part 305: Program Integrity

Part 305 Chapter 1: Program Integrity

Rule 1.1: Fraud and Abuse

A. Title XIX of the Social Security Act, the implementing federal regulations 42 CFR Part 455, and the Mississippi Code of 1972, Title 43 Chapter 13 as amended, set forth the state Medicaid agency's requirements for control of fraud and abuse in the Medicaid program. The Division of Medicaid (DOM) employs detailed methods and procedures to prevent, detect, investigate, report, identify, and collect all improper payments, and impose administrative measures for the control of fraud, abuse, and over utilization practices by providers and beneficiaries. The Mississippi Code of 1972, Title 43 Chapter 13 as amended, describes the penalties related to fraud in the Medical Assistance Program. Suspected fraud/abuse regarding a provider or beneficiary should be addressed to the Division of Medicaid Bureau of Program Integrity. The Division of Medicaid Bureau of Program Integrity should be notified in writing within thirty (30) days of the discovery of any overpayments made by Medicaid caused by billing errors, system errors, human error, etc.

B. Self-Disclosure

1. Providers are urged to self-audit in an effort to identify claim errors and overpayments. The Division of Medicaid Bureau of Program Integrity should be notified in writing within thirty (30) days of the discovery of any overpayments made by Medicaid caused by billing errors, system errors, human error, etc. Providers have an ethical and legal duty to promptly return inappropriate payments they have received from the Medicaid Program. The Division of Medicaid will accept reimbursement for inappropriate payments without penalty in the event that such inappropriate payments are disclosed voluntarily and in good faith, and that the acts that led to the inappropriate payments were not the result of fraudulent or abusive conduct. Any self-disclosure submitted to Division of Medicaid for consideration must include the following information:

    a) Name and address of the affected provider,

    b) If the provider is an entity owned, controlled, or otherwise part of a system or network, include a description or diagram of the pertinent business/legal relationships, the names and addresses of any related entities, and affected corporate divisions, departments, or branches. The description should include the name and address of the disclosing entity's designated representative.

    c) Provider Identification Number(s) associated with claims,

    d) Tax Identification number(s),

e) Payee Identification number(s),

f) Submit affected claims in Excel or Access and should include the following information beneficiary name, claim TCN, procedure code, service from/to date, billed amount, paid amount, paid date, refund amount. (Providers are encouraged to contact the Program Integrity Bureau prior to submitting reports to insure acceptance of information being submitted.)

g) A report that includes a full description of the matter being disclosed, the person who identified the overpayment and the manner in which the individual discovered it,

h) The self-disclosure should include a detailed account of the provider's investigation of the overpayment,

i) A statement disclosing whether the provider is under investigation by any government agency or contractor,

j) A statement detailing the provider's theory regarding the cause of the violation,

k) A certification that the information submitted to the Division of Medicaid is based upon a good faith effort to disclose a billing inaccuracy and is true and correct, and

l) The methodology used in determining the amount of the overpayment (if overpayment amount was determined using a sampling method additional detailed information may be required).

2. The Bureau of Program Integrity reserves the right to verify the financial impact of the disclosed matter. Accordingly, the Division of Medicaid expects to receive documents and information from the entity that relate to the disclosed matter without the need to resort to compulsory methods. Matters uncovered during the verification process which are outside the scope of the self-disclosure may be treated as new matters subject to further investigation.

3. Refunds to the Division of Medicaid for overpayments should be conducted through the claims payment adjustment process or in the form of a refund check within thirty (30) days of the overpayment discovery.

4. Self-disclosure will not absolve the provider of criminal culpability.

C. Corrective Action Plans

1. The Division of Medicaid can require the submission of a Corrective Action Plan to correct deficiencies found during an investigation. Corrective Action Plans must be specific and must, at a minimum, include provisions aimed toward correction of the deficiencies, indicate reasonable completion dates, fully describe the methodology used

to accomplish complete and permanent corrective action, and describe methods for ensuring full compliance with the corrective action plan.

2. The Corrective Action Plan shall be subject to review by the Division of Medicaid to ensure compliance. Violation of the Corrective Action Plan, including failure to implement as directed, will subject the provider to further adverse actions and may be based upon both the initial investigation and the Corrective Action Plan.

D. Overpayments

1. The Division of Medicaid, or designee, sends a demand letter via certified mail requesting the refund of overpayments discovered through audit or investigation.

2. On or before thirty (30) calendar days of the receipt of the demand letter, sent via certified mail, the provider must:

   a) Request a hearing [Refer to Miss. Admin. Code Part 300], or

   b) Refund the overpayment by:

      1) A lump sum payment,

      2) Offsetting against current payments through the claims payment adjustment process until overpayment is recovered,

      3) A repayment agreement executed between the provider and the Division of Medicaid, or

      4) Any other method of recovery available to and deemed appropriate by the Division of Medicaid.

3. The Division of Medicaid will refund any recovered overpayment collected in error to the provider.

E. Suspension of Payments

1. The Division of Medicaid may suspend payments in whole or in part to a provider when there is a pending investigation of a credible allegation of fraud unless the state determines that good cause exists not to suspend such payments. Examples of good cause are the following:

   a) Specific requests by law enforcement that the Division of Medicaid not suspend (or continue to suspend) payment,

b) The Division of Medicaid has determined that other available remedies exist that could effectively or quickly protect Medicaid funds than would implementing (or continuing) a payment suspension,

c) The Division of Medicaid determines that a payment suspension is not in the best interests of the Medicaid program,

d) The Division of Medicaid determines that a payment suspension would have an adverse effect on beneficiary access to necessary items or services, or

e) Law enforcement declines to cooperate in certifying that a matter continues to be under investigation.

2. The Division of Medicaid may suspend payments without first notifying the provider of its intention to suspend such payments as allowed under state and/or federal laws and regulations.

3. The Medicaid Fraud Control Unit (MFCU) can refer to the Division of Medicaid any provider against which there is pending an investigation of credible allegation of fraud for purposes of payment suspension. Referrals from MFCU must be in writing and include information adequate to enable the Division of Medicaid to identify the provider and a brief explanation forming the grounds for the payment suspension.

4. The Division of Medicaid shall make a formal, written suspected fraud referral to MFCU for each instance of a payment suspension as the result of a Division of Medicaid preliminary investigation of a credible allegation of fraud.

F. Notice of payment suspension to Providers

1. The Division of Medicaid must send notice of payment suspension to providers within five (5) days of taking such action. Exception to the five (5) day notice period occurs when the Division of Medicaid receives a written request by law enforcement to delay notification to a provider. Law enforcement can request up to a ninety (90) day delay of notification.

2. The payment notice must set forth the general allegations as to the nature of the suspension of payments, but does not require disclosure of any specific information regarding the ongoing investigation.

3. The notice must:

a) State the payments are being suspended in accordance with 42 CFR Section 455.23.

b) State that the suspension is for a temporary period and cite the circumstances under which the payment suspension will be terminated.

c) Indicate, when appropriate, which type or types of Medicaid claims will be suspended.

d) Inform the provider of the right to submit written evidence for consideration by the Division of Medicaid.

G. All suspension of payments will be temporary and will not continue after:

1. The Division of Medicaid or the prosecuting authorities determines that there is insufficient evidence of fraud, and

2. Legal proceedings related to the provider's alleged fraud are completed.

H. Recovery Audit Contractors (RACs) Program - In accordance with Section 6411 of the Affordable Care Act, the Division of Medicaid will contract with one (1) or more Medicaid RACs for the purpose of identifying underpayments, overpayments and recouping overpayments under the State Plan and under any waiver of the State Plan with respect to all services.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 305, Rule 1.1.D. eff. 10/01/2014; Miss. Admin. Code Part 305, Rule 1.1.B.3. and D.1. revised effective 08/15/2013 to comply with the Medical Assistance Participation Agreement Section C.