Title 23: Division of Medicaid

Part 305: Program Integrity

Chapter 1: Program Integrity

Rule 1.1: Definitions

A. Abuse is defined as beneficiary practices that result in unnecessary cost to the Medicaid program and/or provider practices that are inconsistent with sound fiscal, business, or medical practices that result in:

1. An unnecessary cost to the Mississippi Medicaid Program,

2. Reimbursement for services that are not medically necessary, or

3. Reimbursement for services that fail to meet professionally recognized standards for health care.

B. Credible allegation of fraud is defined as an allegation from any source that has indicia of reliability in which the Division of Medicaid has verified through facts and evidence including, but not limited to, alleged fraud from:

1. Fraud hotline complaints,

2. Claims data mining, and/or

3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

C. Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, or an act that constitutes fraud as defined by federal or state law.

D. Incorrect payment is defined as an error in reimbursement which results in an overpayment or underpayment which may be due to a billing error, systems error and/or human error.

E. Overpayment is defined as an incorrect payment that results in the provider receiving a higher reimbursement than is appropriate for the service provided.

F. Beneficiary error is defined as the client’s incomplete, incorrect or misleading information because the client misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the client’s part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.

G. Waste is defined as the overutilization, underutilization, or misuse of resources.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: Revised and moved language to Rules 1.2-1.4, and 1.6 eff. 11/01/2016; 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.

Rule 1.2: Fraud, Waste, and Abuse

A. The Division of Medicaid investigates suspected cases of fraud, waste, and abuse using methods that:

   1. Do not infringe on the legal rights of persons involved, and

   2. Afford due process of law to individuals under investigations.

B. The Division of Medicaid must make a formal, written fraud referral to the Medicaid Fraud Control Unit (MFCU) for each credible allegation of fraud or an allegation that leads to the initiation of a payment suspension, in whole or in part. If the Division of Medicaid determines that good cause exists to remove a payment suspension, in whole or in part, or to discontinue a payment suspension previously imposed, the Division of Medicaid is not relieved of its obligation to make a referral to MFCU.

C. The Division of Medicaid must suspend all payments to a provider when the Division of Medicaid determines there is a credible allegation of fraud for which an investigation is pending unless the Division of Medicaid determines that good cause exists not to suspend or partially suspend such payments or not to continue a payment suspension previously imposed including, but not limited to:

   1. Law enforcement:

      a) Specifically requesting payments not be suspended, or

      b) Declining to cooperate in certifying that a matter continues to be under investigation.

   2. The Division of Medicaid determining:

      a) Other available remedies exist that could be implemented by the Division of Medicaid to more effectively or quickly protect Medicaid funds,

      b) A payment suspension is not in the best interest of the Medicaid program, or

      c) A payment suspension would have an adverse effect on beneficiary access to necessary items or services because either of the following is true:

1) An individual or entity is the sole community physician or the sole source of essential specialized services in a community, or

2) The individual or entity serves a large number of beneficiaries within a Health Resources and Services Administration (HRSA) designated medically underserved area.

d) A payment suspension should be removed based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension.

D. The Division of Medicaid will notify providers of suspension of payments within five (5) days of the suspension unless requested in writing by a law enforcement agency to temporarily withhold such notice.

E. The Division of Medicaid may grant an administrative hearing, if requested by the provider, as described in Miss. Admin. Code Part 300, to determine whether or not good cause exists to remove a payment suspension or suspend payment only in part.

F. Suspension of payments will continue until:

1. The Division of Medicaid or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider, or

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

G. The Division of Medicaid will:

1. Make a referral to the appropriate law enforcement agency if there is reason to believe that a beneficiary has defrauded the Medicaid program.

2. Conduct a full investigation if there is reason to believe that a beneficiary has abused the Medicaid program or if an applicant made a false statement or failed to disclose a material fact in his/her Medicaid application.

Source: 42 C.F.R. Part 455; Miss. Code Ann. §§ 43-13-121, 43-13-129.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.3: Overpayments

A. Providers must notify the Division of Medicaid's Office of Program Integrity in writing within thirty (30) calendar days of the discovery of any overpayments.

1. Any self-disclosure of overpayments submitted to the Division of Medicaid must include the following information:

a) Name and address of the affected provider,

b) A provider which is entity owned, controlled, or otherwise part of a system or network must include:

    1) A description or diagram of any pertinent business/legal relationships,

    2) The names and addresses of any related and/or affected entities, corporate divisions, departments, or branches, and

    3) The name and address of the disclosing entity's designated representative,

c) Medicaid provider number(s) associated with claims,

d) Tax identification number(s),

e) Payee identification number(s),

f) Affected claims submitted in Excel or Access which must include the following information:

    1) Beneficiary name,

    2) Claim transmittal control number (TCN),

    3) Procedure code,

    4) Dates of service,

    5) Billed amount,

    6) Paid amount,

    7) Paid date, and

    8) Refund amount,

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

h) 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 explanation of the cause of the overpayment,

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.

2. The provider must submit additional information to the Office of Program Integrity as requested in order to verify the information submitted including the financial impact.

3. Any issues discovered during the verification process which are outside the scope of the self-disclosure may be treated as new matters subject to further investigation.

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

5. Self-disclosure does not release the provider from any other cause of action, civil or criminal, by another state agency or department of the United States under applicable law and regulations regarding these payments.

B. The Division of Medicaid, or designee, will send a demand letter via certified mail return receipt requesting the refund of overpayments discovered through audit or investigation:

1. On or before thirty (30) calendar days of the receipt of the demand letter, sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice, the provider must:

a) Request an administrative 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.

2. Providers that fail to refund overpayments as described in Miss. Admin. Code Part 305, Rule 1.3.B.1.b) within the thirty (30) calendar day timeframe, may:

a) Be placed under investigation for waste and/or abuse of the Medicaid program, and

b) Be subject to charges for any allowable interest under state law which will begin accruing thirty-one (31) calendar days after receipt of the demand letter sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice.

C. The Division of Medicaid will accept reimbursement for overpayments without penalty in the event that:

1. Overpayments are disclosed voluntarily and in good faith, and

2. The acts that led to the overpayments were not the result of fraudulent or abusive conduct.

D. The Division of Medicaid will refund any payment recovered in error.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.4: Corrective Action Plan (CAP)

A. The Division of Medicaid may require a provider to submit a Corrective Action Plan (CAP) to correct deficiencies found during an investigation.

1. A CAP must be specific and must, at a minimum, include:

a) Provisions aimed toward correction of the deficiencies,

b) Reasonable completion dates,

c) A full description of the methods used to permanently correct the deficiencies that necessitated the CAP, and

d) A description of methods used for ensuring full compliance with the CAP.

2. The CAP will be subject to approval by the Division of Medicaid to ensure compliance.

B. The determination of a violation of the CAP, including failure to implement as directed, will subject the provider to further adverse actions.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.5: Improper Payments Due to Inaccurate Eligibility Information

A. The Division of Medicaid will identify the cause of any improper payments due to an error in the beneficiary's eligibility information including, but not limited to, incorrect income or deductions, and take corrective action.

B. All underpayments are corrected upon discovery:

    1. Underpayments resulting from agency error may be corrected retroactively.

    2. Underpayments resulting from beneficiary errors are corrected, but they are not corrected retroactively.

C. The Division of Medicaid will attempt to recover the amount of any overpayment from the beneficiary directly or from the beneficiary's state tax refund when the beneficiary provides incorrect eligibility data resulting in an overpayment.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 6 eff. 11/01/2016.

Rule 1.6: Medicaid Eligibility Quality Control

A. A beneficiary must cooperate with Medicaid Eligibility Quality Control (MEQC) reviews.

B. If a beneficiary fails to cooperate with MEQC reviews and an investigator is unable to obtain information needed to complete a review, the case will be referred back to the regional office for a redetermination.

    1. As part of the redetermination process, the information needed by the MEQC will be requested.

    2. If the information is not provided to the regional office, coverage will be terminated because the Division of Medicaid will be unable to determine eligibility.

Source: 42 C.F.R. § 431.810, *et seq*.

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 7 eff. 11/01/2016.