

Fraud, Waste, and Abuse Referral Guidelines for Use by Managed Care Plans

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These guidelines are intended for managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and other managed care entities, all of which will be referred to by the generic term, “managed care plan” (MCP). MCPs should use these guidelines when referring investigations of fraud, waste, or abuse to the program integrity unit of the State Medicaid agency (SMA) or other agency as required by the plan’s contract with the State. These guidelines describe what should be included in the investigative report that should accompany the referral. They are based on a performance standard adopted by the Centers for Medicare & Medicaid Services (CMS) for referrals of suspected fraud from SMAs to Medicaid Fraud Control Units (MFCUs), available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf> on the CMS website. Although the CMS guidelines are for SMAs and do not apply to MCPs, it is helpful for MCPs to follow them, because the ultimate recipient of the MCP’s referrals will often be a MFCU or other law enforcement agency. In addition to following the guidelines, MCPs need to coordinate their fraud investigation and referral efforts with the relevant State agencies.

Initial Contact Information

The report should include the full name, contact phone numbers, and email addresses of:

- The person who reported the fraud, waste, or abuse to the MCP;
- The person who was in charge of the investigation; and
- The person in the MCP who will be the point of contact for the receiving agency.

If the person who reported the fraud, waste, or abuse is employed by or affiliated with an organization, document the name of the organization and its full address, including city, state, and ZIP Code™. Be advised that some persons may wish to report alleged fraud anonymously, but this should not preclude the issue from being investigated. The point of contact at the MCP should be a person who is familiar with the referral, has practical knowledge of the workings of the relevant programs, and will have time to respond promptly to requests for clarification or further information. In addition to contact information, the report should contain the name of the managed care organization and the type of managed care contract.



Details of the Alleged Fraud, Waste, or Abuse

CMS recommends providing all available details related to the fraud, waste, and abuse allegation, including the following information:

Identifying Information

- **For providers:** Include full name of individual or organization, provider type, full address, phone numbers, email address, Medicaid provider number, National Provider Identifier, and license number;
- **For beneficiaries:** Include name, full address, phone numbers, email address, and Medicaid number; and
- **For others:** Include name, organization name (if any), address, phone numbers, and email addresses.

The Suspect's History

A suspect's previous compliance history, including the types of education, training, or other communications that have occurred, may be relevant for establishing the suspect's knowledge of the requirements of the law, rule, or policy that was violated. The report should include any of the following items that relate to the issue being referred:

- Previous complaints, lawsuits, or administrative action;
- Previous training;
- Manuals, bulletins, or other educational materials; and
- Other communications.

The report should disclose any MCP policies, guidance, or informal communications that might be construed by the suspect as making the conduct at issue permissible.

The Managed Care Plan's Actions

Documentation about actions taken by the MCP should include:

- The date the alleged fraud, waste, or abuse was reported to or discovered by the MCP;
- How the alleged fraud, waste, or abuse was detected;
- A description of the conduct of the investigation;
- A list of all persons who were interviewed;
- Interview summaries;
- A list and copies of supporting documentation related to the fraud allegation, such as claims, medical records, and correspondence;
- The names and contact information for any agencies that have been notified of the alleged fraud, waste, or abuse; and
- All corrective actions taken or planned by the MCP.

Factual Explanation of the Alleged Fraud, Waste, or Abuse

Include a complete description of the scheme as understood by the MCP, and provide examples of specific claims that are believed to be fraudulent. The factual explanation should include:

- The date range of the suspected fraud, waste, or abuse and the basis for this range;
- The amount paid to the provider, or on behalf of the beneficiary, during the past three years or during the period of the alleged misconduct, whichever is greater;
- The sample or exposed dollar amount (if available);
- The amount of money recovered, if any; and
- The story of the violation, based on the witness interviews and the records.

Analysis of the Alleged Fraud, Waste, or Abuse

The report should not just recite facts but should include the MCP's analysis of those facts. The analysis should set forth:

- Which law, rule, or policy was violated;
- How the facts prove the violation; and
- Why the receiving agency should devote resources to pursuing the matter.

MCPs that want to obtain more information about referrals should review the presentation, "Managed Care Plans: Critical Partners in the Fight Against Fraud, Waste, and Abuse in Medicaid," which is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/managedcare-toolkit.html> on the CMS website. MCPs that follow these guidelines will improve the chances of having their referrals acted on.

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