

Template C — State War Room Provider Case Presentation
State Medicaid Fraud War Room — Provider Case Summary

Name of Organization: _____

NPI: _____

Date: _____

SECTION 1: ALLEGATION

Describe the allegation, including the nature of the fraud, location, relevant dates, services or payments at issue, and any known co-conspirators or related entities:

SECTION 2: RECOMMENDATION

Recommended Action (check all that apply):

- ☐ Credible allegation of fraud — payment suspension under 42 CFR 455.23
- ☐ Federal exclusion referral — SSA 1128(b)(6) excessive or unnecessary services
- ☐ Federal exclusion referral — SSA 1128(b)(7) fraud / false claims
- ☐ Termination of Medicaid enrollment
- ☐ Referral to MFCU for criminal investigation
- ☐ Referral to HHS-OIG Office of Investigations
- ☐ State licensing board notification
- ☐ Enhanced monitoring / Tier 2 — additional data needed
- ☐ No action at this time / Tier 3 — monitor and close
- ☐ Other: _____

Recommended Tier:

- ☐ Tier 1 — Immediate Action
- ☐ Tier 2 — Enhanced Monitoring
- ☐ Tier 3 — Monitor / Close

SECTION 3: ENROLLMENT INFORMATION

Primary Taxonomy: _____

Practice Address: _____

NPI Enumeration Date: _____

Authorized Official: _____

Owner(s): _____

Medicaid ID: _____

State: _____

Enrollment Status: _____

Enrollment Date: _____

Additional Affiliated Entities or Related NPIs:

SECTION 4: BILLING PROFILE

Medicare

Dates of Service	Amount Billed	Amount Paid	Beneficiary Count	Claim Line Count
From: _____ To: _____	\$ _____	\$ _____		

Medicaid

Dates of Service	Amount Billed	Amount Paid	Beneficiary Count	Claim Line Count
From: _____ To: _____	\$ _____	\$ _____		

SECTION 5: TOP CODES

Code	Description	Amount Paid	Claim Line Count	Anomaly / Notes
		\$ _____		
		\$ _____		
		\$ _____		
		\$ _____		
		\$ _____		

SECTION 6: PROGRAM INTEGRITY HISTORY

Open or Prior Cases: _____

Acceptable Risk Score (ARS) / Risk Score: _____

Prior Administrative Actions (suspensions, terminations, sanctions, overpayment demands):

Prior MFCU or OIG Referrals: _____

Corporate Integrity Agreement on File: ☐ Yes — Status: _____ ☐ No

SECTION 7: REASONS FOR FLAGGING

Check all indicators identified in the data:

- ☐ Services rendered after Medicare or Medicaid revocation
- ☐ Services rendered after provider's license revocation or expiration
- ☐ Claims submitted for services on dates of beneficiary death
- ☐ Claims submitted for beneficiaries who were hospitalized or incarcerated on dates of service
- ☐ Questionable medical necessity — pattern of claims for services not clinically justified
- ☐ Billing at or above maximum allowable units per day or month
- ☐ Total hours billed exceed hours in a day
- ☐ Upcoding — billing higher-complexity codes at more than 3× peer average rate
- ☐ Unexplained billing spike greater than 200% within 90 days
- ☐ Duplicate billing for the same beneficiary and date of service across providers
- ☐ Geographic anomaly — provider location inconsistent with beneficiary concentration
- ☐ Ownership or affiliation with a previously sanctioned, excluded, or revoked individual or entity
- ☐ Suspicious referral patterns suggesting kickback arrangement
- ☐ Billing under credentials of another provider without proper reassignment
- ☐ Other: _____

Narrative — Additional Context Supporting Flagging: