Medicaid Fraud

The purpose of this chapter is to provide instruction and information to staff regarding suspected fraud, waste and abuse in Medicaid-funded programs.
Adult Protective Services staff please refer to Chapter 6 of the Long-Term Care Manual for instructions on reporting fraud.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

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BACKGROUND

Federal regulation requires the Department to have methods and criteria to identify suspected fraud cases, procedures regarding investigation of these cases, and processes for referring suspected fraud cases to law enforcement officials.

When a complaint alleging Medicaid fraud is received, federal rules require the completion of a preliminary determination on whether there is sufficient basis to warrant a full investigation. Because direct line field staff in HCS, DDA and AAA offices conduct case management activities and are often the level of staff receiving this information, the preliminary determination is conducted at this level. If the preliminary results give staff reason to believe that an incident of fraud, waste or abuse has occurred, a referral for full investigation should be made to DSHS ALTSA/DDA Headquarters (HQ) for routing to the Medicaid Fraud Control Unit for their review and evaluation.

The Medicaid Fraud Control Unit (MFCU) conducts criminal and civil investigation and prosecution of health care provider fraud committed against the State of Washington's Medicaid program. MFCU also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and assisted living providers.

The guidance contained in this chapter is based on federal requirements, training materials offered by MFCU, and a collection of practices from field and headquarters program staff. Since this guidance document cannot cover or predict every possible fraud scheme or scenario, this information is presented as a resource to assist staff at reporting agencies when allegations of potential fraud are made, and to better understand the federal reporting requirements associated with Medicaid providers. HCS Headquarters program staff are available for consultation as requested.

Most Medicaid providers are honest, hardworking individuals and agency staff who provide high quality care that enables individuals to continue living in their own home and communities. However, a few individuals attempt to be paid for services they did not provide, for services that the client is not eligible to receive, or by other fraudulent schemes. By identifying provider fraud, we ensure a high-quality provider base to support vulnerable consumers and that taxpayer dollars are used accountably.

PRELIMINARY ACTION STEPS

If a fraud referral is going to be completed do not submit an ARF (Adjustment Request Form). No overpayments can be processed while a fraud referral is active.

If a referral is accepted by Medicaid Fraud Control Unit (MFCU), they will recover any overpayment due.

Case Managers and social services workers are at the front lines of the fight against provider fraud and are in a critical position to identify instances of suspected provider fraud. Reporting agency field staff have the most knowledge of a client/provider situation and are often the point of entry for awareness of

any suspicious acts. Field staff at AAA/HCS/DDA offices may receive information regarding a client or provider's actions that may indicate program rules are not being followed in multiple ways, such as:

- Tip received from an anonymous phone call or letter,
- Observation during regular case management activities,
- Contact by another interested party, or
- Information found in a report or data review.

CDE will also submit fraud referrals to DSHS. The referral will be shared with the local office staff as an FYI. If the Individual Provider is working for other clients, headquarters staff will work with CDE and local office staff to determine if Good Cause Applies (see page 5).

However, before a referral is made to the Medicaid Fraud Control Unit for potential investigation of a provider's actions, a preliminary review must be conducted at the field level or by CDE. This preliminary review contains action steps that are required to establish the credibility of the claim and to determine whether or not field staff or CDE believe behavior which rises to the level of fraud may be involved.

Professional judgment should be applied on a case-by-case basis to determine what steps are appropriate, as all situations are unique. Some steps to take as part of a preliminary review to determine the credibility of the allegation may include the following (if there is any concern that any of these actions might have an unintended influence on a subsequent investigation, contact the Program Integrity Manager for guidance):

- Talk to the client
- Talk to other involved parties
- Request and review the provider' timesheets/records of services provided. For CDE employees HQ staff will request shift details from CDE,
- Review and confirm the care plan and compare to what is being delivered
- Review invoices, staff logs, etc.
- Review the provider's contract file for any relevant documentation
- Gather documentation such as SER notes and/or provider education that occurred prior to current incident
- Consult with supervisor about possible actions before a referral is made, such as:
  - Increased monitoring of services
  - Unscheduled home/office visits (depending on provider type)
  - Conversations with provider regarding the allegation, with appropriate level of detail and reference to program rules (i.e. a reminder not to claim hours while a client is hospitalized).

Allegations are considered credible when they have "indicia of reliability" (see Glossary) or indicators of probability. Examples of some indicators that support the conclusion that the allegation may be true include, but are not limited to:

- Admission/confession to fraud activities,
- Supporting documentation,
- Verification by two or more sources,
- Clear patterns of misconduct,

- Continued misconduct after education on contract requirements (which should be documented in the contract file by the staff person who provided the notification),
- Any internal communications expressing concern about a provider's actions or conduct,
- History of multiple billing "errors", which result in a loss to the Medicaid program,
- A lack of reasonable legitimate explanation, etc.

It should be clear that the act under review is not accidental or inadvertent and is action by design. At the very least, it requires an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit or payment, where the provider has made a knowing false statement. Not every overpayment is fraud, especially where an incident can be attributed to a mistake made by the provider.

If there is no pattern or history of behavior that persists over time, many times the most appropriate administrative remedy is to write an overpayment. When a pattern seems apparent, document the activity and corrective discussion with the provider, as well as any notification that was provided to correct the situation.

This documentation should be made in either the client's SER or the provider's contract file, whichever is most appropriate for the situation. If the behavior occurs again, this information will strengthen a referral as it will help establish a pattern of behavior as well as possible intent of the provider. Field staff should staff concerns with supervisors as appropriate.

Field staff should submit the referral package (see Provider Fraud Referral Policy & Process section for detailed instructions, page 9) with information and supporting documentation that addresses the allegations to the greatest extent possible. See also the Medicaid Provider Fraud Referral form (DSHS Form #12-210) and accompanying instructions for the specific information and required documentation. Following these instructions will provide assurance that quality referrals are submitted to MFCU for their evaluation and review. Be sure that all mandatory fields, those marked with an asterisk ("*"), are completed.

Examples of supporting documentation to submit with a completed referral form may include, but are not limited to:

- Provider Timesheets (if applicable) for a 3-6 month span, for the period of the identified concern,
    - For CDE employees HQ staff will request shift details from CDE,
- Documentation of any overpayment associated with the allegation,
- SER notes that document discussions with the provider regarding either the incident being investigated or any previous discussions with the provider on the same or similar topic,
- Name and contact information of any witness who would be contacted for more information during a full investigation. This could be the person who provided a tip to field staff, or someone who has additional information about the allegation or provider's actions,
- Documentation requested in the Provider Fraud referral form instructions, and
- Any other documents which support and substantiate the allegation.

PAYMENT SUSPENSION POLICY

In accordance with the Affordable Care Act (ACA) and federal regulation at 42 CFR 455.23, the State of Washington must ensure that federal funding is not provided to individuals or entities when there is a pending investigation of a credible allegation of fraud.

This means that system payments to a provider must be suspended when there is a credible allegation of fraud, unless Good Cause exists not to suspend payment. Terminating the provider's payment authorization is the equivalent of a payment suspension. If the payment is not suspended, or suspended only in part, federal rules require that a "good cause" exception must be documented.

- For referrals involving Individual Providers, the CDWA authorization does not need to be ended if CDWA confirms that a new Individual Provider will start serving the client.

Good Cause Exceptions

The federal rule allows that the reporting agency may find that good cause exists to:

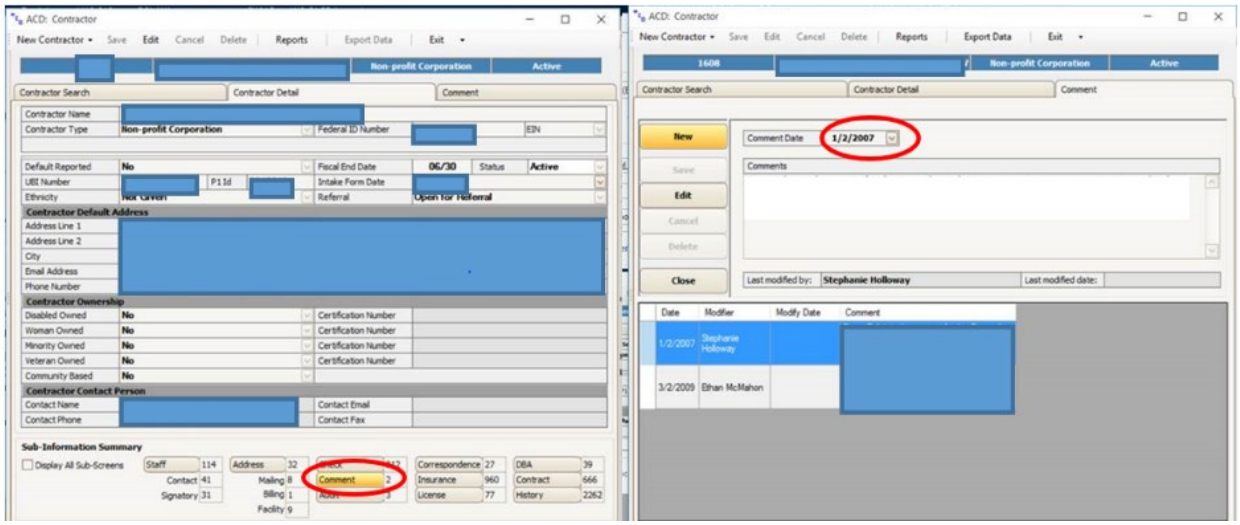
- Not suspend payments,
- Discontinue a payment suspension previously imposed, or
- Suspend payments only in part.

Documentation

If local office staff and CDE recommends that a Good Cause Exception based on client safety needs applies and is approved by DSHS HQ**,** the case manager (or designee) and CDE must ensure the applicable exception is documented, including the relevant facts, circumstances and any other information or supporting documentation to support the finding that a Good Cause Exception applies.

- For a provider with one or only a few clients, such as an Individual Provider, documentation of Good Cause Exception must be made in the client(s)'s SER.
- For Contracted DSHS providers a note in the provider's ACD contract file needs to be added to indicate that a referral was made, the date, a summary of the circumstances, and the Good Cause Exception that applies to the situation.
- For Contracted DSHS provider with several clients, such as an agency provider, documentation of Good Cause Exception must be made in the provider's contract file/ACD. Local or HQ Contract Staff may enter documentation of any monitoring action being considered and add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

NOT Suspend Payment	Suspend Payment in PART
• Case manager must staff the case with Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies.	• The case manager who is making the referral must coordinate with the other case manager(s) of the provider's other clients to determine if there are any concerns regarding the provider. • The case manager must also staff the case with their Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies to suspend only in part.



Not Suspend Payment

If there is a good reason not to terminate the authorization of a provider (i.e. to allow a provider to continue working for the client) when a credible allegation of fraud is referred for potential investigation, this reason is called a Good Cause Exception and must be documented. **42 CFR §455.23** includes a provision for a good cause exception to not suspend payments. Allowable **Good Cause** reasons to either (1) NOT suspend payments, or (2) NOT continue a payment suspension previously imposed are:

Payment Not Suspended Due to Good Cause Exception

- MFCU (or other law enforcement agency) specifically requests that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.
- Based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, the suspension should be removed.
- Client access to care would be jeopardized by a payment suspension because of either of the following: (please indicate)
  - (i) The individual or entity is the sole source of essential specialized services in a community.
  - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- Payment suspension is not in the best interests of the Medicaid program.

Suspend Payment Only in Part

The federal rule allows that the reporting agency may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part if there is a good reason to allow an individual or entity to continue working where there is an investigation of a credible allegation of fraud.

Suspending a payment only in part would be applicable when a provider has more than one client, the credible allegation of fraud is regarding only one client, and there are no issues with the remaining client(s). The applicable exceptions to suspend payment only in part are as follows:

Payment Suspended Only in Part Due to Good Cause Exception

- Client access to care would be jeopardized by a payment suspension in whole or part because of either of the following: (please indicate)
  - (i) The individual or entity is the sole source of essential specialized services in a community.
  - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- The reporting agency determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that the previously imposed payment suspension should be imposed only in part.
- The credible allegation focuses solely and definitively on only a specific type of business area of a provider, and the reporting agency determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- The reporting agency determines that payment suspension only in part is in the best interests of the Medicaid program.

If none of the exceptions apply, the payment authorization must be terminated when a provider fraud referral is submitted to MFCU. Notice to the provider regarding the termination of the payment authorization must be sent within five (5) of the termination date on the authorization, in accordance with the federal requirement at 42 CFR 455.23(b).

PROVIDER FRAUD REFERRAL POLICY AND PROCESS

Considerations Before a Referral is Made

A referral should contain sufficient information to support the Department's belief that an illegal act by a Medicaid provider has occurred. There is **no** "minimum dollar threshold" which must be met in order to make a provider fraud referral. If staff suspect a situation is Medicaid fraud, a referral should be made using the guidance presented in this chapter. Intake staff at the MFCU will review and evaluate cases referred by DSHS and make a determination to accept a case for further investigation and potential

prosecution based on the information presented and their agency's criteria. Field staff should not "screen out" or decide not to make a referral based on an assumption that a case might not be accepted due to dollar value.

Before a provider fraud referral is submitted to HQ for referral to MFCU, the referring staff (i.e. case manager or contract manager) must staff the referral package with supervisor(s) and/or others per AAA or regional practice. This should include a review of the allegation circumstances, all relevant supporting information and documentation, and a determination regarding payment suspension, documenting good cause exception where applicable. Supervisor review should ensure all required components of the referral are met according to the referral form instructions, and to ensure appropriate professional judgment has been applied to the process.

Submitting the Medicaid Provider Fraud Referral Package

Complete the Medicaid Provider Fraud Referral form (DSHS Form 12-210) according to the form instructions, gather all appropriate documentation (see Preliminary Action Steps section), and submit this package to the email addresses listed in the table below. HQ program staff monitors the email inbox on a daily basis. **Reporting agency field staff should not make any provider fraud referrals directly to MFCU**, either via email, phone, or through the online complaint form. MFCU Intake Unit staff are available for consultation upon request, if field staff would like to consult regarding a case before considering it for referral.

For ALTSA Home & Community Services (HCS) Division Referrals	For Development Disabilities Administration (DDA) Referrals
Send referrals to this email address: ProviderFraudHCS@dshs.wa.gov	Send referrals to this email address: ProviderFraudDDA@dshs.wa.gov

HCS and DDA HQ program staff monitor the email Inbox regularly to receive referrals. These are reviewed for completeness and compliance with federal regulations, and then entered into a tracking system. Provider fraud referrals are reported to this centralized location for tracking purposes related to quality assurance and annual reporting. This process facilitates collaboration with Health Care Authority's Division of Program Integrity (DPI) and ensures a standardized reporting process is followed in order to meet mutual reporting requirements to federal authorizing entities.

HCS and DDA HQ program staff will forward the completed referral package along with any supporting documentation to the appropriate investigating entity, MFCU and/or the DSHS Office of Fraud and Accountability (OFA), as appropriate. HQ program staff will monitor, track, and report on the follow-up provided by the fraud investigators, as well as communicate with case managers and field staff as needed on a case-by-case basis.

Notices to Client and Provider

Send the appropriate notice to the Client and provider according to current practice and policy. Include WAC and CFR citations from the Resources section at the end of this chapter, as applicable, as well as any other applicable WACs which support the action being taken.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee.

Payment authorization to provider should be end dated according to the Payment Suspension section, unless a Good Cause Exception applies. When a fraud referral is made, terminate payment to the provider immediately and according to the Payment Suspension section, unless a Good Cause Exception applies, or client selects another CDE IP. Contact the provider about the termination and send written notice within five (5) days of the termination date on the authorization. Contact the client for care planning purposes and send a PAN.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee

Documentation of Referral

The referring field staff must ensure the provider fraud referral is documented, including the date of referral, relevant facts, circumstances and any other information or supporting documentation.

- For a provider with one or only a few clients, such as an Individual Provider employed CDE, document the referral in the client(s)'s SER.
- For a provider with several clients, such as an agency provider, a notation in the provider's contract file must be added to document the date of referral, relevant facts, a summary of the circumstances, and any contract or monitoring action being considered. Add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

FULL INVESTIGATION

Cases that are accepted by MFCU for investigation will be assigned to a MFCU Investigator, who may contact field staff to request cooperation and records related to the provider being investigated. An investigation will continue until the appropriate legal action is initiated, or the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse. A matter may also be resolved between the agency and the provider through other means, such as a warning notice to the provider, assessing an overpayment, terminating the provider's contract, or other sanctions as appropriate.

HCS and AAA field staff and case management staff as well as HQ program staff will cooperate fully with the investigatory and prosecutorial activities of the MFCU to the extent allowed by law and rule. This includes providing access to records or information kept by the reporting agency as well as making records and/or reports available upon request. An example of records which may be requested include a copy of the provider contract and any documents signed by the provider at contracting indicating awareness of and willingness to comply with program policies.

Further, DSHS and its contractors will cooperate with Health Care Authority staff with regard to the prevention and detection of fraud, waste and abuse as outlined in the Cooperative Agreement between DSHS and HCA, and by extension through the Memorandum of Understanding between MFCU and HCA.

WHEN A REFERRAL IS NOT ACCEPTED BY MFCU

When a referral is screened out or declined by MFCU, field staff will receive notification from either HCS/DDA program staff or from MFCU staff directly. Field staff may then decide to resume payment to a provider for either the same client or a different client. For agency providers, this may mean that a previously imposed payment suspension in part would be ended. Before resuming payment or ending any payment suspension consider if a Character, Competence & Suitability Review is appropriate.

- For an agency provider, please reference Policy & Procedure Manual for AAA Operations, Chapter 6: Interlocal Agreements, Subcontracts and Grievances for guidance related to contract monitoring activities.
- Staff with case management supervisor to ensure awareness of prior referral activity.
- Document CCS results in provider's contract folder and add a Comment to the provider's Contractor Profile in ACD with the CCS results and any monitoring activities or report(s).
- CDE will perform CCS as appropriate for their employees.

CONTRACT TERMINATION

According to DSHS Central Contract and Legal Services (CCLS), termination of a contract for default means a contractor is not in compliance with the expectations or requirements of the contract. Requests for termination for default must be staffed with a supervisor, then submitted to the Contracts Unit for routing to CCLS who makes the final review and determination of default.

The reporting agency may determine that a provider's contract should be terminated as the result of the actions or activities that gave rise to the provider fraud referral. Please refer to information presented in other chapters of the LTC Manual regarding contract termination processes, such as Chapters 3 and 5, or AAA Policy and Procedure Manual, Chapter 6.

Contract terminations resulting from a Medicaid Provider Fraud Referral are an annual reporting requirement to HCA and CMS, so this information is collected on the Medicaid Provider Fraud Referral form as well as through follow up with case management staff by HQ program staff. Reporting agency staff should respond promptly to any inquiry made by HQ program staff about planned contract action following a provider fraud referral.

REPORTING CLIENT FRAUD

The Office of Fraud and Accountability (OFA), an office within DSHS, investigates Medicaid client fraud. MFCU and OFA may collaborate on investigations that may involve both a client and a provider. When an intake report, tip received, or investigation indicates that a client may have committed fraud involving Medicaid funds, suspected client fraud should be reported to OFA using the Fraud Early Detection (FRED) process through Barcode. Some DSHS staff may not have access to Barcode. If this is

the case, the referring worker should complete the DSHS 12-209 Client Fraud Report form and send via email to the correct email addresses listed above.

RESOURCES

Related WACs and RCWs

WAC 388-71-0540 – 388-71-0561	Home and Community Services and Programs
RCW 74.66	Medicaid Fraud False Claims Act
74.67	Medicaid Fraud Control Unit
9A.56.030	Theft, 1st degree
9A.56.020(b) (4) & (5)	Theft by Deceptions
CFR 42 CFR §455.2	Definitions
42 CFR §455.12- 42 CFR §455.17	Preliminary & Full Investigation Requirements
42 CFR §455.21	Cooperation with State Medicaid Fraud Control Units
42 CFR §455.23	Suspension of Payments and Good Cause Exception

Acronyms

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACD	Agency Contracts Database
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protection Services
CCLS	Central Contracts and Legal Services
CCS	Character, Competence and Suitability Review
CDE	Consumer Directed Employer entity.
CDWA	Consumer Direct Care Network of Washington, the contracted CDE entity
CMS	Centers for Medicare and Medicaid Services
DDA	Development Disabilities Administration
DPI	Division of Program Integrity within Health Care Authority
DSHS	Department of Social and Health Services
FRED	Fraud Early Detection with OFA
HCA	Health Care Authority
HQ	DSHS ALTSA & DDA Headquarters
LTC Manual	Long Term Care Manual
MFCU/MFCD	Medicaid Fraud Control Unit/Division
OFA	Office of Fraud and Accountability
PAN	Planned Action Notice
SER	Service Episode Record
The Department	Department of Social and Health Services

Glossary

For purposes of Medicaid Fraud, and according to 42 CFR 455.2, the following definitions apply:

WORD	DEFINITION
Abuse	(meaning for this term as it is used within this chapter and not as it applies to Adult Protective Services investigations) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Credible allegation of fraud	Is an allegation which has been verified by the reporting agency (see definition below), received from any source, such as complaints received or observations during case management. Other sources could be patterns identified through report review or provider audits, information resulting from civil cases, or law enforcement investigations. Allegations are considered to be credible when they have "indicia of reliability" (see definition below) and the reporting agency (see definition below) has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Fraud	Means 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. It includes any act that constitutes fraud under applicable Federal or State law.
Indicia of reliability	Are signs, indicators or circumstances, which tend to show or indicate that something is probable.
Reporting agency	Refers to DSHS (also referenced within this chapter as "the Department") or any contracted AAA entity. This could mean any HCS, DDA, or AAA office.
Waste	Is defined as any activity that uses resources but creates no value. While all fraud is waste, not all waste is fraud. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, or excess administrative costs.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/2/20225/20/2026	Cheryl Timmons	Updated language of Good Cause process and added language to include CDE providers	n/a
01/06/2025	Cheryl Timmons	Added language about overpayments, made some grammar changes.	

APPENDIX

- 12-210 Provider Fraud Referral Form,
- 12-209 Client Fraud Referral Form,
- FRED link in Barcode (screenshot),
- Provider Fraud Fact Sheet – November 2014
- H17-023 (Amended 5/22/2017)