Fraud, Waste, and Abuse

Policy: 613
Section: Administrative Requirements

SD CFCS/PCS
Community Services Bureau
Senior and Long-Term Care Division

Purpose

Fraud, waste, and abuse (FWA) divert significant resources away from necessary Medicaid services. FWA include any actions or inactions that constitute fraud and abuse, under federal or state law, and can be committed by both Community First Choice Services (CFCS)/Personal Care Services (PCS) providers and by member beneficiaries. For additional information and support regarding Medicaid fraud in Montana, please see the state's Medicaid Fraud and Abuse website.

Fraud, Waste, or Abuse Coordination

The Department's Surveillance and Utilization Review Section (SURS) and the Medicaid Fraud Control Unit (MFCU) protect the integrity of the Montana Medicaid program. If provider or member FWA is suspected, the regional program officer (RPO) must be contacted, a serious occurrence report (SOR) must be completed in the Department's Quality Assurance Management System (QAMS), and a referral to SURS must be completed.

Note: All providers of CFCS/PCS are mandated by state law to report any reasonable or known suspicions of fraud, waste, abuse, neglect, and/or exploitation. If there is reasonable cause to suspect that a member is experiencing or at risk of experiencing fraud, waste, abuse, neglect and/or exploitation, the appropriate entities (i.e., Child/Adult Protective Services, law enforcement, Office of the Inspector General (OIG), etc.) must be contacted. For additional information regarding mandatory reporting, please see § 52-3-811, M.C.A. and § 41-3-201, M.C.A..

Procedure and Referral

When someone reports suspected FWA, the Department of Public Health and Human Services (DPHHS) will begin an investigation. OIG leads this process.

- When a suspected incident of Medicaid FWA is reported, the provider agency must notify the RPO, complete an SOR, and submit a referral to SURS. Referrals can be made by calling one of the following numbers:
    - Recipient Eligibility Fraud Hotline: (800) 201-6308
    - Recipient Abuse (Team Care) Fraud Hotline: (800) 362-8312
    - Provider Fraud Hotline: (800) 376-1115
- SURS will conduct a preliminary investigation to determine if there is enough reliable information to move forward with a full investigation.
- If the preliminary investigation indicates potential provider FWA, the case will be referred to the MFCU.
    - For cases that do not meet the MFCU referral standard, SURS will conduct a full investigation and process based on SURS's outlined criteria.

- For cases in which a member is suspected of FWA, the OIG Intentional Program Violation (IPV) unit will conduct a full investigation or refer the case to the appropriate law enforcement agency.
- In all cases, the program is informed when a SURS case is resolved/closed.

Fraud, Waste, and Abuse Prevention

The provider is responsible for being knowledgeable about sections of the Administrative Rules that relate to their provider type, program policies, and covered services. Additionally, any individual or entity that furnishes, or is authorized to furnish, Medicaid services, including personal care attendants (PCA) employed by a provider agency, must not be excluded from participation in federal health care programs. This means:

- Providers are responsible for ensuring their employees, including PCAs, are not listed on the OIG's List of Excluded Individuals/Entities (LEIE) or other applicable exclusion lists.
- Providers are encouraged to conduct monthly checks of the LEIE.
    - The monthly screening should apply to all individuals with direct or indirect involvement in Medicaid services, including administrative staff, billing personnel, and especially those providing hands-on care.
- Provider agencies are encouraged to keep records documenting that monthly checks are occurring. This documentation should include the:
    - date of each check,
    - name of the person/entity checked,
    - result (cleared or flagged), and
    - action taken if a match was found.
- The LEIE can be accessed through the official U.S. Department of Health and Human Services OIG website: LEIE Searchable Database. This site allows:
    - searching for individuals or entities by name,
    - downloading the full exclusion list, and
    - accessing monthly supplement updates.
- These documents may be part of a quality assurance review.

Definitions

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that it could result in an unauthorized benefit to themselves or another person.

Waste: The overuse or inappropriate use of services and misuse of resources, typically not a criminal or intentional act.

Abuse: Provider or beneficiary practices that are inconsistent with sound fiscal, business, or medical practices, resulting in unnecessary costs or reimbursement for services that are not medically necessary or fail to meet professional standards.

References

Arm 37.85.402 Provider Enrollment And Agreements

Code Annotated (M.C.A.):
MCA 45-6-313, MCA 52-3-811, and MCA 41-3-201

Code of Federal Regulations (CFR) :
42 CFR § 1001.1901 – Scope and effect of exclusion,
42 CFR § 455.17, 42 CFR § 455.2,
§ 455.14 Preliminary investigation, and
§ 455.15 Full investigation

Supersedes

New Policy