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**Managed Care Program Integrity Manual**



Office of Program Integrity

State of Tennessee | Division of TennCare

Version 10 – January 1, 2024

# **Revision History**

## Previous Revisions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | | | **Revision(s)** | |
| 03/01/2019 | | Initial version | |
| 07/01/2020 | | **Additions include** Liquidated damages, additional definitions, verbiage to detail and align contract with manual directives, and other to clarify, or update instructions.  **Updates include** Investigation extension request, Referral Form and Checklist, Figure 1, adding CFR, TN Codes, and contract sections, and various general updates such as changing MFCU to MFCD, grammar, formatting, incorporating the footnote information in the main document, reorganization of sections, and spelling changes throughout document. The Appendices now includes usable master copies of all TennCare Report Templates. | |
| | Reorganization Crosswalk | | | --- | --- | | Previous Organization | Where Previous Sections are Now Located | | Intro to PI | Program Integrity Overview | | 1. Employee and Provider Education | Section 9 Deliverables | | 1. FWA compliance Plan | Section 9 Deliverables | | 1. Contract Deliverables | Section 9 Deliverables | | 1. Tips of Potential Fraud and Abuse | Section 1 Tips of Potential FA | | 1. FA Investigation Requirements | Section 2 FWA Investigations | | 1. Referrals for Suspected Fraud and Abuse | Section 9 Deliverables | | 1. Identifying and Recovering Overpayments | Section 4 Identifying & Recovering Overpayments | | 1. Claim Tags | Section 9 Deliverables | | 1. Pre-Payment Review | Section 3 Administrative Actions | | 1. Excluded Individuals and Entities | Section 5 is an overview, Section 9 Deliverable | | 1. Administrative Action | Section 3 Administrative Actions | | 1. RFI and ORR | Section 9 Deliverables | | 1. Monthly Calls | Section 8 Communications Management | | 1. On-Site FA Meetings | Section 8 Communications Management | | 1. Provider Alert Lists | Section 7 Provider Alert List | | 1. Provider Subcontracts | Section 6 Provider Subcontracting | | 1. Appendix | Section 10 Appendices | | | | | |
| 01/01/2021 | **Updates include:** Grammar, OAG to AG/MFIO, formatting, spelling, definitions, aligned appendix, detailed language in several areas to define/clarify, inclusion of Katie Beckett in reports where appropriate, medical records request procedures, due date changed on Compliance Plan and Annual Policies, Audit Exposure form updated, Disclosure Summary Rate report and EOB report moved to Tabs 10 & 11 in QFA report, language for each report adjusted to reflect merge in QFA, Bi-Monthly Tips report changed to a Monthly Tips report. Added new reports for 2021 (Denied Credentialing Summary Form, Non-Registered Provider Payment Report, PCS Audit report information), removed Claim Tag report requirement, added language to include claims recovery over 365 days (normally included in Claims Tag report) to Annual Recoveries report and QFA report. | | | | |

01/01/2021 (V3.1) Disclosure Submission Rate Report (DSRR) requirement has been removed, Monthly Dispensing Report and EOB requirement has been removed for OptumRx, Denied Provider Credentialing report has changed from a monthly to quarterly submission, Appendix E has been revised from a Word document to an Excel spreadsheet summary, Appendix D has been revised (TAB 11 (DSRR) has been deleted), Appendix N has been revised (Columns B, C, F)

07/01/21 **Additions include:**

* Definitions
* Targeted Education Section
* Section 10: DIDD Information
* Program Integrity Policy Links
* 42 C.F.R. Part 455 Subpart B Attestation Updated

**Updates include:**

* General spelling and grammar revisions
* PAL Section
* Deliverable Chart
* Compliance Plan and Crosswalk
* Annual Policies and Crosswalk
* QFA Spreadsheet Formatting and Tab Organization Sections
* Audit Exposure Form Section
* Unapproved Subcontractor report
* Section 2.3, 6, and 9.1
* Documenting Administrative Actions
* Deliberate Ignorance definition updated

01/01/22 **Additions include:**

* MCPIM Key Requirements Section
* Public Partnership, LLC, and Morning Sun Financial Services Section

**Updates include:**

* Compliance Plan due date moved to February 15th
* Unsolicited provider refunds
* 90 day prepay guidelines
* Medical record request section clarified
* Section 7.2 Provider Initiated Overpayment Recovery from PAL provider was moved to Section 9.16.
* Two reports changed to ad hoc
* Exposure forms clarified usage and when to submit to OPI
* QFA Summary Tab revised, and instructions now included as notes
* Compliance Plan crosswalk revised
* Referral Form revised
* DIDD section reworked
* Table 1: Deliverables updated
* General grammar, spelling, acronyms corrections
* Definition updates
* Compliance plan Section L & M reworked

01/01/22 **Additions include:**

* MCC must seek approval prior to deviating from MCPIM requirements
* Naming conventions for deliverables
* SFTP server instructions for organization
* OPI exposure notifications
* Notification template for cases/investigations over 270 days

**Updates include:**

* General cleanup of acronyms, formatting, and grammar
* Compliance Plan due date moved to March 1st
* Provide more detailed expectations for:
  + - * + Medical Record Requests
        + PAL report
* Revised templates:
  + - * + FWA Activities – added formula protection and cell validation
        + Referral Checklist – added instructions to form
        + Cost Avoidance report – added column for program name
        + Exposure form – added instructions to form

07/01/22 Updates include

* + - * + MCPIM definitions reviewed against CRA to ensure alignment
        + Adding naming conventions
        + Medical Records Review Request section clarified
        + New 270 Day Notification Templates and instructions
        + **Monthly Report**: a column was added “TennCare Exposure”
        + **FWA Activities report**:
        + Tips Tab: “TennCare Exposure (Yes/No)” column added
        + Summary Tab:

Use the MCC Tracking Number to obtain the total number of new tips

“Overpayments and Savings” section has changed to only “Overpayments” **do not include prepayment review savings in this section**.

Prepayment review savings will continue to be reported in **Tab 3 Audits Performed** in the QFA report **and reported in the Cost Savings Report.**

* + - * + **Monthly Report:** “TennCare Exposure (Yes/No)” column added
        + **Referral form:** added section for addresses for consumer direction caretaker and member if allegation is living together.
        + Updated Exposure form, Referral Checklist (added instructions), Cost Avoidance
        + **Items changed after MCC review/Q&A are in yellow highlights**

01/01/23 Updates include:

* Documenting Administrative Action Section
* Sections reworked:
  + - * + Provider-Initiated Overpayments section/report
        + OPI Exposure Notifications
        + Office of Program Integrity Inservice Training
        + Compliance Plan Section
        + Monthly Tips report
        + QFA Summary Tab
        + QFA Audits Performed and Referrals Made– closed date clarified
        + Notification of exceeding 270 days
        + Provider education
* Draft referrals are now required prior to formal submission
* All deliverable templates now have the effective date on them, you must use the templates within the MCPIM V8 -whether it has been revised or not. There has been confusion on the most current template, this will help OPI confirm the correct template is being used.
* Various templates have been revised

|  |  |
| --- | --- |
| 07/01/2023 | * Includes appropriate revisions, and new/revised templates as outlined in the MEMO sent March 5th & 17th for deliverable changes. |
|  | * Cost Savings report revised |
|  | * Non-Registered Provider Payment report revised |
|  | * Monthly Involuntary Terminations report retired information now reported in the QFA report |
|  | * Notification of Exceeding 270 Days revised |
|  | * Monthly Tips report revised to align with QFA report |
|  | * QFA report Referral Tab Column G deleted, Audit Tab Column N |
|  | * QFA Summary logic change for number Referrals Closed-deleted |
|  | * Denied Provider Credentialing |
|  | * Annual Recoveries |
|  | * Summary Report for All Program (New Report) * Update to Referral Form to include City, State, Zip in Provider Address section |
|  | * Report instructions revised/streamlined throughout Section 9 |
|  | * Exclusion Section revised |
|  |  |

Current Revisions

|  |  |
| --- | --- |
| **Date** | **Revision(s)** |
| 01/01/2024 | Changed Preface wording |
|  | Section 4.11 and Section 9 on Provider Issued Refunds |
|  | Tips Report – added a column for CDTN to note when the tip was sent to the MCO |
|  | FWA Activities report:   * EOB tab categories were removed, MCCs will complete the categories. * Summary tab- "New Tips” logic column changed since MCO column was added last revision. This does not change the logic that was implemented. |
|  | Medical Record Release section |
|  | TTPL added in 5.1 |

Although we try to track all changes it is up to each MCC to review the guidance manual for updates.

# **Preface**

Each of TennCare’s managed care contractors (MCCs) operate under its own policies and procedures, often resulting in inconsistent implementation of program integrity requirements across the organizations. The purpose of these guidelines is to define requirements for MCC program integrity operations and documentation, as well as clarify expectations for activities related to the prevention, detection, investigation, and referral of potential or suspected fraud and/or abuse.

The requirements set forth in this manual are supplemental to the program integrity requirements outlined in all Division of TennCare managed care contracts, and the TennCare Operations Manual. A MCC must seek approval from TennCare’s Office of Program Integrity prior to deviating from the requirements of the manual, or managed care contracts. Notification must be given immediately if an MCC is non-compliant on any requirement.

The TennCare Office of Program Integrity reserves the right to conduct audits on managed care contractors’ compliance with these requirements, and to implement corrective actions, up to and including assessment of liquidated damages up to $5,000 per incident, per day as appropriate.

This manual is intended solely for use by TennCare personnel, managed care contractors, and any other personnel who are actively engaged in either evaluating the performance of program integrity processes and/or carrying out the procedures contained within.

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# **Definitions**

**Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2) Tenn. Comp. R.& Reg.1200-13-13-.01(1)

**Audit**: Audits are conducted of health care provider records, financial information, and statistical data according to principles of cost reimbursement to determine reasonableness and allowance of costs reimbursable under the TennCare program. Audits may be prospective or retrospective in nature. Tenn. Comp. R.& Reg.1200-13-18-.02(4)

**Benefits**: The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to TennCare members enrolled in the managed care contractor’s (MCC’s) network. Tenn. Comp. R.& Reg.1200-13-13-.01(5)

**Case**: An investigation of fraud and/or abuse that may be referred to TennCare Office of Program Integrity (OPI), Tennessee Bureau of Investigation Medicaid Fraud Control Division (TBI MFCD), Tennessee Office of the Attorney General Medicaid Fraud and Integrity Division (AG/MFID), and/or Office of Inspector General (OIG) by an MCC’s Special Investigations Unit (SIU) which also includes DIDD Risk Management with documented allegations that a provider, subcontractor, beneficiary, or other entity has

* Engaged in a pattern of improper billing,
* Submitted improper claims with actual knowledge of their truth or falsity, or
* Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

The term “case” will be used as an inclusive term to represent, audits, cases, and investigations.

**Case Files:** a collection of documents and/or evidence related items held either physically or electronically which pertain to a case. held in a central location either physically or electronically.

**Case Tracking System (CTS):** a system that electronically manages cases and is used to document key actions through the lifecycle of the case. The CTS may also be used as a document repository and records management system for case files and records.

**Centers for Medicare and Medicaid Services (CMS)**: The agency within the United States Department of Health and Human Services (HHS) that is responsible for administering Titles XVII, XIX, and XXI of the Social Security Act (the Act).

**Claim**: A request for payment for services and benefits provided to a member. See also the definition in Tenn. Comp. R.& Reg. 1200-13-18-.02(7)

**Cloning of Medical Notes:** Documentation is considered cloned when each entry in a medical record for a beneficiary is worded exactly like or like the previous entries. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and their situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

**Complaint**: See “Tip”.

**Contract Provider**: A provider that contracted with, or has signed a provider agreement with, the MCC to provide covered services. Tenn. Comp. R.& Reg.1200-13-13-.01(24)

**Contractor Risk Agreement (CRA)**: The contract between the Contractor and TennCare regarding requirements for operation and administration for the managed care TennCare program, including CHOICES and I/DD MLTSS Programs. 42 CFR § 438.3; Tenn. Comp. R.& Reg.1200-13-13-.01(26)

**Covered Service**: A medically necessary service or supply for which TennCare benefits may be available. Tenn. Comp. R.& Reg.1200-13-13-.01(31)

**Credible Allegation of Fraud**: An allegation of fraud which has been evaluated by the Office of Program Integrity, using information from any source, including:

* Fraud hotline complaints,
* Claims data mining, and/or
* Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judicially on a case-by-case basis. (42 CFR 455.2) Tenn. Comp. R.& Reg. 1200-13-18-.02(11)

**Current Dental Terminology (CDT) (or Code on Dental Procedures and Nomenclature)**: A medical code set of dental procedures, maintained, and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

**Current Procedural Terminology (CPT)**: A medical code set of physician and other services, maintained, and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

**Deficit Reduction Act:** Requires state Medicaid plans to provide that any entity that receives or makes annual payments under the state plan of at least $5 millionper year must provide certain information to its employees, contractors and agents concerning federal and state false claims act provisions, penalties, and protections.

**Deliberate Ignorance:** Means that the provider has deliberately chosen to ignore the truth or falsity of the information on a claim submitted for payment, even though the provider knows, or has notice, that information may be false.

**Dental Benefits Manager (DBM)**: An entity responsible for the provision and administration of covered dental services, as defined by TennCare. Tenn. Comp. R.& Reg. 1200-13-13-.01(33)

**Department of Health and Human Services (HHS)**: The federal government agency tasked with provision of health and human services and fostering advances in medicine, public health, and social services. HHS provides oversight of CMS.

**Determination**: A decision made to either pay in full, pay in part, or deny a claim.

**Division of TennCare (TennCare)**: The division of the Tennessee Department of Finance and Administration (the single State Medicaid agency) that administers the TennCare program.

**Durable Medical Equipment (DME)**: Purchased or rented items, such as hospital beds, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient’s home, which are covered by Medicaid. Tenn. Comp. R.& Reg. 1200-13-13-.01(38)

**Edit**: Logic within the MCC’s claims processing system that selects certain claims and evaluates or compares information on the selected claims (or other accessible source) and—depending on the evaluation—acts on the claims, such as pay in full, pay in part, or suspend for manual review.

**Enrollee**: A person who has been determined eligible for TennCare or CoverKids and who has been enrolled in the TennCare or CoverKids program (see Member, also). Synonymous with Member. For purposes of TennCare Enrollee Benefit Appeals and the TennCare Enrollee Benefit Appeal-related provisions in Section A.2.19 of the CRA, “Enrollee” means (1) TennCare or CoverKids enrollee, (2) TennCare or CoverKids enrollee’s parent, (3) TennCare or CoverKids enrollee’s legal guardian, or (4) TennCare or CoverKids enrollee-Authorized Representative.

For purposes of provider agreements in Sections A.2.12.23, and missed visits of home health services in Section A.2.15.9 of the CRA, “Enrollee” means not only (1) the enrollee, (2) the enrollee’s parent, or (3) the enrollee’s legal guardian, but also a person who has a close, personal relationship with the enrollee and is routinely involved in providing unpaid support and assistance to them.42 CFR § 438.2; Tenn. Comp. R.& Reg. 1200-13-13-.01(42)

**Excluded Services**: Services or supplies that are not covered by Medicaid. Tenn. Comp. R.& Reg. 1200-13-13-10(3)

**Excluded Provider**: A provider who is prohibited from participation in federally funded health care programs and can receive no payment from federal health care programs for any items or services they furnish, order, or prescribe. Provider exclusions may be either mandatory or permissive. 42 CFR § 1001.601; Tenn. Comp. R.& Reg. 1200-13-18-.07

* Mandatory exclusions: The Department of Health and Human Services Office of Inspector General (HHS-OIG) is required by law to exclude from participation in all federal health care programs individuals or entities convicted of the following types of criminal offenses: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), or other state health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.
* Permissive exclusions: HHS-OIG has the discretion to exclude individuals and entities on a number of grounds, including misdemeanor convictions related to health care fraud other than Medicare, Medicaid, or a State health program, fraud in a program (other than a health care program) funded by a federal, state, or local government agency; misdemeanor convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances; suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a federal health care program; engaging in unlawful kickback arrangements; defaulting on health education loan or scholarship obligations; and controlling a sanctioned entity as an owner, officer, or managing employee.

**Facility**: An institution that provides inpatient or long-term care services.

**False Claims Act**: As set out in 31 U.S.C. 3729 *et seq*, there may be civil liability for any person or organization that knowingly files a false claim or makes a false record seeking payment from the U.S. government services or supplies. The State of Tennessee has a similar statute, the Tennessee Medicaid False Claims Act which is set out in T.C.A. 71-5-181 *et seq*

**Fee-for-Service**: A method of making payment directly to a provider for health services or supplies based on a fee schedule that specifies payment for defined services.

**Fee Schedule**: The maximum fee that an MCC will pay for specified covered services.

**Fraud**: 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 (see 42 CFR 455.2).

**Healthcare Common Procedure Coding System (HCPCS)**: A medical code set that identifies health care procedures, equipment, and supplies for claims submission purposes. HCPCS Level 1 contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the medical code set.

**Investigation**: A review of a provider’s services and/or claims submissions in response to a tip or allegation of potential or suspected fraud or abuse. Investigations shall include a retrospective review of claims and may be supplemented by provider and member interviews and provider research (see also “Case”).

**Involuntary Termination**: An action taken in which the State Medicaid program or MCC revokes a provider’s or supplier’s billing privileges, a provider has exhausted all applicable appeal rights, or the timeline for appeal has expired, and there is no expectation on the part of the provider or supplier that revocation is temporary.

**Knowingly:** To ‘‘knowingly’’ present a false or fraudulent claim means that the provider: (1) Has actual knowledge that the information on the claim is false; (2) acts in deliberate ignorance of the truth or falsity of the information on the claim; or (3) acts in reckless disregard of the truth or falsity of the information on the claim. It is important to note the provider does not have to deliberately intend to defraud the Federal Government to be found liable under the Federal False Claims Act 31 U.S.C. 3729 *et seq* or the Tennessee False Claims Act (T.C.A. §71-5-181).

**Law**: Statutes, codes, rules, regulations, and/or court rulings.

**Managed Care Contractor (MCC)**: An entity that provides Medicaid health benefits and services through contracted arrangements with the State Medicaid agency. TennCare has contracts with various types of MCCs:

* Managed Care Organizations (MCOs), which provide a comprehensive package of health benefits and services to TennCare members. Tenn. Comp. R.& Reg.1200-13-13-.01(70) MCOs are full-risk entities that receive capitation (per member, per month) payments to provide services. TennCare has entered into Contractor Risk Agreements with three (3) MCOs providing services to members statewide; and
* Prepaid Ambulatory Health Plans (PAHPs), which provide a limited benefit package that does not include inpatient hospital or institutional services. TennCare has statewide contracts with two PAHPs—a Dental Benefits Manager (DBM) and a Pharmacy Benefits Manager (PBM). The DBM has a partial-risk agreement and the PBM has a non-risk agreement with TennCare in which they are reimbursed for services provided, as well as an administrative fee.
* Prepaid Inpatient Health Plan (PIHP), which provides physical and behavioral health and long-term services and support for enrollees selected for participation in TennCare Select, rather than one of the full-risk MCOs. TennCare Select has a non-risk agreement for which it is reimbursed for services provided, as well as an administrative fee.

* The State Medicaid agency also has entered into an Interagency Agreement with the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) to organize delivery of long-term services and supports to members receiving benefits through the State’s 1915(c) home and community-based service (HCBS) waiver programs.

**Medically Necessary (or Medical Necessity)**:

Medical Necessity and Medically Necessary as used in the manual shall have the meaning contained in Tenn. Code Ann. 71-5-144, TennCare Rule 1200-13-16, and other TennCare rules, as applicable

**Medical Records:** medical, behavioral health, and long-term care histories; records, reports, and summaries; diagnoses and prognoses; record or treatment given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

**Medical Review**: A review of Medicaid claims and medical records to ensure that the service was medically necessary and appropriate.

**Member**: An individual covered under a MCC’s health plan (see also “Enrollee”). TCR 1200-13-13-.01(80)

**National Correct Coding Initiative (NCCI)**: A program developed by CMS to promote national correct coding methodologies and to control improper coding leading to improper payments. CMS developed its NCCI coding policies, which are updated annually, based on coding conventions defined in the AMA’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. NCCI coding edits are categorized as follows:

* Procedure-to-Procedure (PTP) edits, which are used to prevent improper payment when incorrect code combinations are reported
* Medically Unlikely Edits (MUEs), which are used to prevent improper payment when services are reported with incorrect units of service
* Add-on Code edits, which are used to prevent improper payment when an HCPCS/CPT add-on code is incorrectly reported with a primary procedure code

**National Provider Identifier (NPI)**: A unique identification number for covered health care providers under the Health Insurance Portability and Accountability Act (HIPAA). Providers must share their NPI with other providers, health plans, clearinghouses, and/or any other entities that may need it for billing purposes. Entities that do not meet the definition of a health care provider do not qualify for NPIs, such as billing services, health plans, non-emergency transportation services, and others who do not furnish health care.

**Non-Contract Provider**: Any provider that is not directly or indirectly employed by or does not have a provider agreement with the MCC, or any of its subcontractors, pursuant to the TennCare CRA. Tenn. Comp. R.& Reg. 1200-13-13-.01(82)

**Non-Participating Provider**: See “Non-Contract Provider”. Tenn. Comp. R.& Reg. 1200-13-13-.01(83)

**Obligation**: an established duty, whether or not fixed, arising from an expressed or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment”. 31 U.S.C. 3729(b)(3) and TCA 71-5-182(d).

**Office of Attorney General Medicaid Fraud and Integrity Division:** The division of Tennessee that is responsible for civil prosecution of violations of the Tennessee Medicaid False Claims Act. See TCA 71-5-183.

**Office of Inspector General**: – The State of Tennessee agency that investigates and may prosecute civil and criminal fraud and abuse of the TennCare program or any other violations of state law related to the operation of the TennCare program administratively, civilly or criminally. See also [T.C.A. §71-5-2505](https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=73108418-07c8-4c78-9075-f2b27977cd8f&nodeid=ACSAAFAAXAAF&nodepath=%2FROOT%2FACS%2FACSAAF%2FACSAAFAAX%2FACSAAFAAXAAF&level=4&haschildren=&populated=false&title=71-5-2505.+Authority.&config=025054JABlOTJjNmIyNi0wYjI0LTRjZGEtYWE5ZC0zNGFhOWNhMjFlNDgKAFBvZENhdGFsb2cDFQ14bX2GfyBTaI9WcPX5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A4WYF-MWN0-R03J-S1GH-00008-00&ecomp=-_57kkk&prid=b6a889f7-3627-4b87-877d-218533aec0f4)2

**Office of Program Integrity:** The State Medicaid Agency unit responsible for the prevention, detection and investigation of alleged provider fraud, waste, and abuse of the TennCare program. See also 42 CFR 455.

**Offset**: See “Withhold”.

**Overpayment**: The amount paid by an MCC or the State Medicaid agency to a provider which is more than the amount that is allowable for services furnished and which is required to be refunded (42 CFR 433.300 et seq). Medicaid overpayments occur in many contexts, including but not limited to:

* The member was not eligible for Medicaid at the time the service was provided,
* The MCC or State Medicaid agency has made a payment where there was another responsible payer,
* The service was not covered by Medicaid,
* The service was covered but not medically necessary, or
* Medicaid was the responsible payer for a medically necessary, covered service, but the payment amount was incorrect and excessive.

**Overutilization**: The provision or prescription of Medicaid benefits or services more than what is medically necessary for the member or authorized by the Plan, which either directly or indirectly results in unnecessary costs to the health care system. Tenn. Comp. R.& Reg. 1200-13-13-.01(88)

**Participating Provider**: See “Contract Provider”. Tenn. Comp. R.& Reg. 1200-13-13-.01(89)

**Payment Suspension** The withholding of payment to a provider or supplier of an approved Medicaid payment amount when there is reliable information (TCP.PI 12-001) that:

* An overpayment exists, but the amount of the overpayment is not yet determined
* The payments to be made may not be correct
* The provider fails to furnish records and other essential information necessary to determine the amounts due to the provider
* A credible allegation of fraud exists

**Provider Review Committee (PRC)**: Comprised of representatives from TennCare’s OPI, Office of Provider Services, Office of Managed Care Operations, and the TennCare Office of General Counsel, the PRC reviews cases of suspected provider fraud and abuse to determine if the degree of fault supports a credible allegation of fraud.

**Pharmacy Benefits Manager (PBM)**: An entity responsible for the provision and administration of pharmacy services. Tenn. Comp. R.& Reg. 1200-13-13-.01(91)

**Post-Payment Audit/Review**: An evaluation of claims and medical records submitted by a provider for which payment has been made by the MCC. Post-payment audits/reviews are frequently conducted to identify incorrectly paid claims, identify problematic policies and procedures, and to confirm potential or suspected fraud or abuse.

**Pre-Payment Audit/Review**: An evaluation of claims and/or medical records submitted by a provider for which payment has not yet been made by the MCC. Pre-payment audits/reviews are frequently conducted on providers who have demonstrated patterns of billing errors and require the provider to submit medical records to the MCC prior to claim adjudication.

**Prior Authorization**: The act of authorizing specific health care services or items before they are provided. Tenn. Comp. R.& Reg. 1200-13-13-.01(101)

**Prospective Review**: See “Pre-Payment Review”.

**Provider**: An institution, facility, agency, physician, health care practitioner, personal care services, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent). Tenn. Comp. R.& Reg. 1200-13-13-.01(103)

**Provider Agreement**: An agreement, using the provider agreement template approved by the Tennessee Department of Commerce and Insurance, between the MCC and a provider that describes the conditions under which the provider agrees to furnish covered services to the MCC’s members.

**Provider Participation Agreement**:The contract between the provider and the state of Tennessee which allows the provider to get a Medicaid provider ID number and therefore participate in the TennCare program, in exchange for the Provider’s promise to follow all the laws, rules, guidelines, policies and contracts that govern said program.

**Reckless Disregard:** To act in ‘‘reckless disregard’’ means that the provider pays no regard to whether the information on a claim submitted for payment is true or false. An example of a provider who submits a false claim with reckless disregard would be a physician who assigns the billing function to an untrained office person without inquiring whether the employee has the requisite knowledge and training to accurately file such claims.

**Recoupment**: The process by which an MCO, the State of Tennessee or the Federal government, or any of their Bureaus, Agencies or Contractors recover Title XIX monies paid to an MCO, provider or enrollee.

**Referral**: Documentation submitted to TennCare OPI and TBI MFCD demonstrating suspected fraud and/or abuse by a provider in the MCC’s network. A referral consists of a variety of information, including post-payment review of the provider’s claims and associated overpayment amounts, previous education received by the provider for improper claims activity, provider status and history with the MCC, and MCC policies and guidelines relevant to the allegations of suspected fraud or abuse.

**Refund**: The process of recouping improper payments made by the MCC to the provider in which the provider returns the funds in either a lump sum or via a payment arrangement with the MCC. Refunds may be initiated by the provider or the MCC by means of an overpayment demand letter.

**Regulatory Requirements**: Any requirements imposed by applicable federal, state, or local laws, rules, regulations, court orders and consent decrees, program contracts, or otherwise imposed by TennCare in connection with the operation of the program or the performance required by either party under an agreement.

**Retrospective Review**: See “Post-Payment Audit/Review”

**Shall**: Indicates a mandatory requirement or a condition to be met.

**State**: Any entity or agency of the State of Tennessee, including the Tennessee Department of Finance and Administration (F&A), the Tennessee Office of Inspector General, the Division of TennCare, the Tennessee Bureau of Investigation, the Tennessee Department of Commerce and Insurance (TDCI), the Comptroller’s Office, and the Office of Attorney General.

**Subcontract**: An agreement entered into by the MCC with any other organization or person who agrees to perform any administrative function or service for the MCC specifically related to securing or fulfilling the MCC’s obligations to TennCare under the terms of the CRA (e.g., claims processing, recovery audits). “Subcontract” shall also include an agreement entered into by a provider with any other provider or entity to provide covered health care services or items, personal care services, or administrative functions, under the terms of the provider agreement.

**Subcontractor**: Any organization or person who provides any function or service for the MCC specifically related to securing or fulfilling the MCC’s obligation to TennCare under the terms of the CRA. “Subcontractor” shall also include an organization or person who provides any covered health care services or items, personal care services, or administrative functions under the terms of the provider agreement.

**Targeted Education:** An MCC’s communications to a provider that address specific claims submission deficiencies identified in an audit or by other means.  The education shall be clear, and informative enough so the provider will understand it, and can correct the deficiencies.

**TennCare Program (or “TennCare”)**: The program administered by the single state Medicaid agency, as designated by the State and CMS, pursuant to Title XIX of the Act and the Section 1115 demonstration waiver granted to the State of Tennessee, and any successor programs.

**Tennessee Bureau of Investigation Medicaid Fraud Control Division**: In accordance with T.C.A. 71-5-2508, TBI MFCD has the authority to investigate and refer for prosecution violations of all applicable state and federal laws pertaining to provider or vendor fraud in the administration of the State Medicaid program, the provision of medical services or supplies, the activities of providers of medical services or supplies in the State Medicaid program, allegations of abuse or neglect or patients in health care facilities receiving payment under the State Medicaid program, Medicare fraud, misappropriation of patients’ private funds in such facilities, and allegations of fraud and abuse in board and care facilities. T.C.A. 71-5-2508

**Tennessee Department of Commerce and Insurance (TDCI)**: The state agency having the statutory authority to regulate (among other entities) insurance companies and health maintenance organizations.

**Tennessee Department of Finance and Administration (F&A)**: The state agency that oversees all state spending and acts as the chief corporate office of the State. F&A is Tennessee’s single state Medicaid agency. The Division of TennCare falls under the oversight of F&A.

**Tennessee Department of Intellectual and Developmental Disabilities (DIDD)**: The state agency contracted by TennCare to serve as the operational administrative agency for day-to-day operation of Section 1915(c) HCBS waivers for persons with intellectual disabilities. DIDD is responsible for the performance of contracted functions for Employment and Community First (ECF) CHOICES, as specified in the Interagency Agreement.

**Tip**: A statement—oral or written—alleging that a provider or member received a Medicaid benefit of monetary value, directly or indirectly, overtly, or covertly, in cash or in kind, to which he or she is not entitled under current federal or state Medicaid law, regulation, or policy, or under applicable MCC policy. Included are allegations of misrepresentation and violations of Medicaid requirements by persons or entities that bill for covered items or services.

**Unbundling**: Occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Unbundling may be used by providers to manipulate coding to maximize payment.

**Underutilization**: The provision or prescription of health services or benefits to a lesser extent than what is medically necessary for the member. Underutilization of services can translate into higher health care costs, diminished health, and lost productivity over the lifetime of the TennCare member.

**Upcode**: To increase the value and code of a claim when the documentation does not support the level of service billed by a provider.

**Utilization Review**: See “Medical Review”.

**Waste:** The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

**Withhold**: The process of recouping improper payments made by the MCC to the provider by reducing payments on future claims.

# **Program Integrity Overview**

## Purpose

As of September 2020, over [77 million](https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html) individuals were enrolled in Medicaid and CHIP in the 51 states and is a significant and increasing component of federal and state budgets. Medicaid grew 2.9% to $613.5 billion in 2019, or 16 percent of the total National Health Expenditures [(NHE)](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet), it is the second largest health insurance program after Medicare and is estimated to constitute the second largest share of total state spending. To ensure the integrity of public health care funds, Medicaid program integrity regulations have been implemented at the state and federal level for preventing, detecting, and investigating potential or suspected fraud and abuse, as well as reporting and recovering improper payments.

Fraud, abuse, and waste in Medicaid costs states billions of dollars every year. According to the Government Accountability Office (GAO), improper payments totaled an estimated $36.7 billion in fiscal year 2017—funds that could have otherwise been used for legitimate health care services. In addition to increasing the cost of Medicaid without adding value, fraudulent and abusive practices increase the risk and potential for harm to patients by exposing them to unnecessary procedures.

## What is Fraud, Waste, and Abuse?

Fraudulent and abusive activities may be conducted by providers, MCCs, vendors, subcontractors, or members during delivery or receipt of health care services or goods, or through administration of the program, and may take many forms, including:

* Incorrect reporting of diagnoses or procedures to maximize payments
* Billing for services not furnished and/or supplies not provided, including billing for appointments that the member failed to keep
* Billing that appears to be a deliberate application for duplicate payment for the same services or supplies or billing both Medicaid and a third-party insurer attempting to be paid twice
* Altering claim forms, electronic health records, medical documentation, etc., to obtain a higher payment amount
* Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., payment for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment)
* Unbundling, separating, or “exploding” charges
* Completing documentation—such as, writing prescriptions, making claims, writing in charts, and completing Certificates of Medical Necessity—for patients not personally and professionally known by the provider
* Participating in schemes that involve collusion between a provider or supplier and an MCC employee (e.g., the provider or supplier deliberately overbills for services and the MCC employee adjudicates the claims)
* Billing for “gang visits” (e.g., a physician visits a nursing home and bills for multiple nursing home visits without furnishing a specific service to individual patients)
* Misrepresenting dates and/or descriptions of services furnished or the identity of the member or the individual who furnished the services
* Billing non-covered or non-chargeable services as covered items
* Using another member’s Medicaid ID to obtain medical care
* Giving false information about provider ownership
* Denial of valid claims submitted by the provider
* Obtaining medications or products that are not needed and selling them on the black market
* Providing false information to apply for benefits or services
* Doctor shopping to obtain multiple prescriptions
* Overstating the MCC’s cost in paying claims
* Misleading members about health plan benefits
* Undervaluing the amount owed by the MCC to a provider under the terms of its agreement

## Waste and Other Types of Improper Payments

An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts include overpayments and underpayments. Improper payments may include any payment that was made to an ineligible provider, payments for non-covered services, duplicate payments, payments for services not rendered, and payments that are for the incorrect amount. In addition, when a Medicaid agency or MCC review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment should also be considered an improper payment. Although improper payments are frequently attributed to fraud and abuse, they can also occur because of other actions or factors, including:

* Waste, which is the overutilization, underutilization, or other misuse of resources that result in unnecessary costs to the Medicaid program, such as providing services that are not medically necessary
* Data processing errors, which are errors resulting in an over- or underpayment that is determined from a review of the claim(s) and other information in the Medicaid Management Information System (MMIS), related systems, and other outside sources of provider verification
* Medical review errors, which are errors resulting in an over- or underpayment that are determined from a review of the provider’s medical record(s) or other documentation supporting the service(s) claimed

## What is Medicaid Program Integrity?

Program integrity is the management of Medicaid to provide quality and efficient health care services and safeguard state and federal program funds. Program integrity activities focus on:

* Accurately determining eligibility of members
* Ensuring prospective and current providers meet state and federal participation requirements
* Confirming that medically necessary and appropriate services have been provided to members
* Identifying other insurers or programs that may be responsible for a member’s care to ensure Medicaid remains the payer of last resort
* Ensuring providers’ payments are made in the correct amount and only for covered services

The Deficit Reduction Act of 2005 (DRA) included multiple provisions intended to strengthen efforts by the federal and state governments in addressing fraud and abuse in the Medicaid program, including grants for states which could be used for program integrity initiatives and financial incentives for states to enact state false claims acts. The DRA also required organizations that receive $5 million or more in Medicaid reimbursements to provide employees with education and detailed written policies regarding:

* The federal False Claims Act
* Administrative remedies for false claims and statements
* Civil and/or criminal penalties under state false claims laws, if applicable, and
* Whistleblower protections under federal and state law

The Affordable Care Act (ACA), passed in 2010, also contained multiple provisions aimed at combatting Medicaid fraud, waste, and abuse, including:

* Provider screening, enrollment, and reporting requirements
* Termination of a provider’s participation in Medicaid if the provider was terminated under another state or federal health care program
* Required registration under Medicaid for billing agents, clearinghouses, or other alternate payees
* Prohibition on payments for institutions or entities located outside the United States
* Payment suspensions for providers or entities under investigation or litigation for a credible allegation(s) of fraud
* Incorporating National Correct Coding Initiative (NCCI) methodologies in Medicaid claims processing systems
* Requirements to report overpayments within 60 days of identification

## Program Integrity and Medicaid Managed Care

Under managed care, the state pays the MCC a capitated rate and provides oversight of the MCC’s Medicaid program operations, while the MCC pays its contracted providers for health care services provided to its enrolled Medicaid members.

On May 6, 2016, CMS finalized federal rules that outline requirements for both states and MCCs in a multitude of areas, including program integrity-related activities. Prior to publication of these rules, state requirements for MCCs varied and many states struggled with monitoring MCC operations. Program integrity requirements detailed in the rules include:

* Screening, credentialing, and enrollment of MCC network providers who order, refer, or render covered services (42 CFR 455, Subpart E)
* Implementing procedures for internal monitoring, auditing, and referral of MCC compliance issues (42 CFR 438.608(a)(1)(iv))
* MCC reporting of potential fraud, abuse and/or waste to the state (42 CFR 438.608(a)(7))
* MCC reporting of changes in member and/or provider circumstances which may impact participation (42 CFR 438.608(a)(2) and (3))
* Suspension of payments to network providers when the state determines a credible allegation of fraud exists (42 CFR 438.608(8))
* MCC submission of complete, timely, and accurate encounter data to the state (42 CFR 438.818)

## TennCare and Program Integrity

The Division of TennCare (TennCare) administers the state’s Medicaid program, including the state’s Children’s Health Insurance program (CoverKids), to nearly 1.7 million Tennesseans with an annual budget of approximately $13 billion. The TennCare program was initially launched on January 1, 1994. Using a CMS 1115 Demonstration waiver, the State of Tennessee became the first state to deliver health care services to 100 percent of its Medicaid enrollees through managed care.

During the early years of TennCare’s implementation, it faced multiple and substantial issues—including some related to MCC oversight and program integrity—which threatened its viability. In 2002, the Tennessee General Assembly passed the TennCare Reform Act, which laid out measures that would enable the program to move forward. The TennCare Reform Act was the basis for the program’s re-design known as “TennCare II” (hereafter referred to as TennCare) that began on July 1, 2002, under a new CMS 1115 Demonstration waiver. Among its provisions, the TennCare Reform Act required the Bureau of TennCare (as the Division was previously named) to establish a program integrity unit to investigate and, as appropriate, refer to law enforcement cases of potential or suspected fraud or abuse. It also required TennCare to have administrative remedies for the recovery of improper payments made for program benefits and services.

Since its creation, TennCare’s Office of Program Integrity (OPI) has grown in function and is now comprised of two units—investigations and compliance. The investigations unit collaborates with the MCCs and law enforcement agencies to investigate, refer, and prosecute suspected fraud and abuse committed by TennCare providers. The compliance unit oversees MCC program integrity activities, including documentation, reporting, and compliance with contractual and regulatory requirements, along with the requirements outlined in this Managed Care Program Integrity Manual (MCPIM).

TennCare OPI is also responsible for the Provider Review Committee (PRC), which is comprised of representatives from OPI, the Office of Provider Services (Provider Services), and the Office of Managed Care Operations (Managed Care Ops). The PRC also consults with TennCare’s Office of General Counsel (OGC). When the State has identified a degree of fault that may rise to the level of suspected provider fraud and abuse, the matter is referred to the PRC. The PRC reviews the matter to determine if the degree of fault supports a credible allegation of fraud. If it is determined that a credible allegation of fraud exists, the PRC refers the matter to the TBI MFCD and may place the provider on a payment suspension, pending the outcome of the investigation. Payment suspension determinations are made in consultation with the MCCs and TBI MFCD to ensure that the action will not have a negative effect on TennCare members or any ongoing investigations.

Many other TennCare offices and divisions play a role in ensuring program integrity. Managed Care Operations, the Dental Director, and the Pharmacy Director develop and monitor contracts with the MCOs, the DBM, and PBM, respectively, and Provider Services screens and enrolls all providers. This enrollment process includes verifying the providers are not excluded or disbarred from participation in Medicare, Medicaid, or other federal or state health care programs. Once providers are screened, they are assigned a TennCare identification (ID) number. A TennCare ID number is required for all providers. Additionally, the Office of the Medical Director and the Division of Quality Oversight review issues of medical necessity and quality of care. OGC handles matters related to recovery of overpayments and provides consultation on program integrity-related issues.

TennCare operates a mechanized claims processing and information retrieval system, in accordance with 42 CFR 433.116, which provides patient and provider profiles for program management and utilization review purposes. Information obtained from or developed by the system related to probable fraud or abuse is also made available to TBI MFCD.

## The Role of Other Entities in TennCare Program Integrity

**Managed Care Contractors (MCCs)**. The MCCs are responsible for making payments for covered Medicaid services and benefits provided to TennCare members and, therefore, are the first line of defense in preventing and detecting potential or suspected cases of fraud, abuse, and waste. MCC program integrity-related activities include:

* Using data analysis to identify incidents of potential fraud, abuse, and waste that exist within its network and taking appropriate action on each case
* Providing targeted education and oversight to providers demonstrating improper or aberrant billing practices
* Investigating allegations of fraud and abuse made by members, providers, suppliers, and other sources, as applicable
* Implementing appropriate administrative actions where there is reliable evidence of fraud or abuse, including pre-payment review, payment suspension, and/or termination from the network
* Referring cases of provider and administrative fraud to TennCare OPI and TBI MFCD and cases of member fraud to OIG for consideration of civil and criminal prosecution and/or application of administrative sanctions
* Working closely with TennCare OPI on joint projects, investigations, and other proactive, anti-fraud activities

**Tennessee Bureau of Investigation Medicaid Fraud Control Division**. TBI MFCD is required to be “separate and distinct” from TennCare, in accordance with 42 CFR 1007.9(a) and T.C.A. 71-5-2508.TBI MFCD is responsible for investigating and referring for prosecution suspected fraud in the administration of the Medicaid program, the provision of medical assistance, and/or provider activities under the State’s Medicaid Plan (42 CFR 1007.11). TennCare OPI refers all cases of suspected provider fraud to TBI MFCD and provides access to requested records, information, and data, as required by 42 CFR 455.21. In addition, TBI MFCD is authorized to investigate allegations of abuse or neglect or patients in health care facilities receiving payment under the State Medicaid program, Medicare fraud, misappropriation of patients’ private funds in such facilities, and allegations of fraud and abuse in board and care facilities. See T.C.A. 71-5-2508 and 42 CFR 1007.11.

**Tennessee Office of Attorney General**. Under T.C.A. 71-5-181 et seq., AG/MFID is responsible for pursuing civil action against providers suspected of violating the Tennessee Medicaid False Claims Act to recover improperly paid Medicaid funds.

**Tennessee Office of Inspector General**. OIG’s mission is to identify, investigate, and prosecute persons who commit fraud against TennCare, including members, providers, and contractors. The authority of OIG is set out in T.C.A. §71-5-2505, and among other things, it does the following:

* Investigate civil and criminal fraud and abuse of the TennCare programs, including allegations of fraud or abuse involving TennCare MCCs
* Refer instances of provider fraud and abuse to TBI MFCD
* Furnish the public with information about the fraud and abuse laws pertaining to TennCare
* Provide legal assistance to AG/MFID and the District Attorney’s General in initiating and handling proceedings in TennCare fraud and abuse cases, as appropriate, including criminal prosecutions, civil recoveries, and forfeitures
* Employ qualified law enforcement officers with authority to enforce the fraud provisions
* Pay cash rewards to citizens who provide information regarding TennCare fraud which leads to a criminal conviction
* Subpoena witnesses and records in connection with any investigation into TennCare fraud or abuse

**Health and Human Services.** HHS**-**OIG's mission is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve. The goals and objectives of HHS-OIG is to fight fraud, waste, and abuse (FWA), prevent, detect, and deter FWA, foster sound financial stewardship and reduction of improper payments, and hold wrongdoers accountable and recover misspent public funds. HHS-OIG also promote quality, safety and value, and advance excellence and innovation.

# **Key Requirements**

This section is provided solely to present an overview of the investigation timeline and required documenting, mailing, and tips and investigations. Each MCC shall review this entire manual for a full understanding of all requirements. Throughout the manual all documentation and timeframe requirements refer to audits, cases, and investigations.

* **The MCC will have a CTS** that allows key documentation to be uploaded and retained within. Alternative document storage may be allowed if approved by OPI.
* **The MCC has 45 days from the time a tip is received** to conduct an initial review to determine what action(s) shall be taken in response to the allegation.
* **All FWA tips must be submitted on the monthly tip report**, including tips that have not yet been assigned, have been screened out, and/or have been closed with no action.
* **All key actions must be documented in the CTS.** Key actions and uploaded documentation shall show the progression of a case that anyone can review and gain full knowledge of the case. Items considered key actions include, but are not limited to, provider review/education/overpayment notification letters, tracking information, provider verification of receipt, overpayment calculations and sample details, dates for medical records received, reviews initiated, and reviews completed, communications with state partners, and any interviews attempted/conducted and/or any other communications.
* The **CTS must be updated at a minimum** once every month for each case that is actively being investigated or under development.
* If medical records for post pay reviews are not received within the guidelines of medical requests, the MCC shall notify OPI to discuss appropriate next actions.
* There is **a maximum of 45 days from the date the tip is received** to screen and resolve the tip.
* The MCC has **270 days** from the date a tip is assigned to complete an investigation. **Figure 1 provides the lifecycle of a Tip and Investigation.**
* An MCC **must notify OPI** if any cases will **exceed 270 days using the template provided in Appendix R**.
* MCC’s **shall notify OPI** within 10 days of any providers who voluntarily terminates its contract while under investigation or payment review. See Section 2.1.
* **After 120 days of a pre-payment review** an investigation shall be initiated or the provider has received targeted education according to Section 2.1.
* **Expedited referrals** are due **within 15 calendar days** from OPI’s request date.
* **For each investigation, a staff member shall be designated** that possesses a **thorough knowledge regarding the structure of investigations, procedures, processes, and the location of documentation**. The staff member would have the **ability to step in quickly** if an emergency arose to ensure the **continuous coverage of critical investigative duties** and able to respond to provider investigation related inquiries from TennCare and other State agencies.

# **Section 1: Tips of Potential Fraud, Waste, and Abuse**

Investigations of potential or suspected fraud, waste, and abuse stem from allegations that a provider or supplier received Medicaid reimbursement for which he or she is not entitled under current federal or state laws, regulations, or policies. All allegations—or tips—must be reported to TennCare OPI and screened by the MCCs to determine if additional investigation is warranted.

## 1.1 Identifying Tips

MCCs shall have mechanisms in place for identifying and/or receiving all tips of potential or suspected fraud and abuse and shall include both internal and external sources. Mechanisms may include:

* Fraud reporting hotlines
* Electronic reporting via the MCC’s website or email
* Audits, including medical reviews and quality audits
* Data mining, including provider profiling and utilization trending; and/or
* Interagency reports

If a tip with TennCare Exposure is identified through a national effort it should be referred to the SIU for triage.

## 1.2 Reporting Tips

MCCs shall submit tips of all potential or suspected fraud and abuse to both OPI and TBI MFCD using the Monthly Tips report template (Appendix C) and the Quarterly Fraud and Abuse Activities report template (Appendix D) provided by TennCare OPI.

MCCs are also required to submit tips of potential or suspected fraud and abuse by TennCare members to the Tennessee OIG. Requirements for the format and frequency of submitting tips of member fraud and abuse are set by OIG

MCCs are also required to immediately submit any allegations in connection to the provision of Medicaid services of potential or suspected patient neglect, physical and/or sexual abuse, and financial exploitation of any members to the TBI MFCD, which also has the responsibility of investigating those types of cases. See 42 CFR 1007.11 and TCA 71-5-2508.

## 1.3 Evaluating Tips

The MCC has 45 days from the time a tip is received to conduct an initial review to determine what action(s) shall be taken in response to the allegation(s), including:

* Pre-payment review,
* Audit/investigation,
* Provider education, and/or
* Unsubstantiated/close.

MCCs are responsible for determining the order in which tips are screened or analyzed; however, a priority should be placed on screening or analyzing tips received from individuals or entities (i.e., hotline, electronic communication, external agencies, etc.) If the MCC has not completed evaluation or acted within 45 calendar days of the tip being assigned, TennCare OPI may assume responsibility for screening and subsequent investigation of the tip. In the event of this occurrence, TennCare OPI shall direct the MCC to cease all action related to the tip and provide written direction to the MCC for submitting all relevant and available information and documentation. Additional information regarding the actions and timeframes for evaluating tips and initiating investigations can be found in Figure 1.

TennCare OPI understands that the use of algorithms to identify potential or suspected fraud and abuse may produce a substantial number of provider tips, which may be placed in a queue while higher priority cases are being screened or investigated. Therefore, MCCs are not required to submit provider tips identified solely by algorithms until additional review or data analysis begins.

# **Section 2: Fraud, Waste, and Abuse Investigations**

If an MCC determines that a tip of potential or suspected fraud or abuse warrants further evaluation, it may either place the provider on pre-payment review and/or initiate an investigation. From the date the provider is placed on pre-payment review and/or an investigation is initiated, the MCC has 270 days to complete a retrospective review of the provider’s activities and either submit a referral (Appendix F&G) to TennCare OPI and TBI MFCD or close the case. Additional information regarding the actions and timeframes for pre-payment review and investigations can be found in Figure 1 below.

If a provider voluntarily terminates from the MCC’s network upon initiation of, or during, a pre-payment review or investigation, the MCC shall notify the TennCare OPI Compliance Manager via email within 10 business days. Notification to TennCare shall also include the provider’s name, NPI, and the reason he or she was placed on pre-payment review.

## 2.1 Pre-Payment Review

MCCs may choose to place a provider suspected of fraud or abuse on pre-payment review to 1) evaluate the provider’s current claim submissions to determine if the aberrant billing practices are continuing and/or 2) prevent additional overpayments due to the provider’s incorrect or fraudulent claims. If a MCC places a provider on pre-payment review due to potential or suspected fraud or abuse, after 120 days, an investigation shall be initiated, or the provider has received education and steps shall be taken to remove the provider from pre-payment review with targeted education at a minimum of every 120 days.

MCCs shall be aware that placing a provider on pre-payment review following a tip of potential or suspected fraud or abuse **does not** extend the 270 day time requirement for submitting a referral or closing a case. **The 270 day timeframe begins on the day the tip is assigned for pre-payment review or investigation.**

Example 1: If an MCC chooses to place a provider on pre-payment review and initiate an investigation on the same day, it would have 270 days to complete the investigation.

Example 2: If an MCC chooses to place a provider on pre-payment review and does not initiate an investigation until day 89 following the implementation of pre-payment review, it would have 181 days to complete the investigation.

MCCs shall document the occurrence of all key actions taken for providers on pre-payment review in either the provider’s file or the MCC’s case tracking system. Key actions may include:

* Provider notification of pre-payment review,
* Education furnished to the provider related to their claim’s activities,
* Change in the scope of the pre-payment review (e.g., increasing or decreasing the number of codes reviewed),
* Initiation of a retroactive investigation, and
* Termination of pre-payment review.

Additional information on pre-payment review requirements can be found in Section 3.

## 2.2 Intentionally Left Blank

## 2.3 Investigation Documentation

Detailed and accurate documentation of investigations is vital in assisting TennCare OPI and TBI MFCD in pursuing and acting on credible allegations of fraud. In addition, it can aid MCCs in monitoring compliance with their policies and procedures related to methods of investigation. Therefore, MCCs shall have in place a case management or documentation system that will be used to record key actions and findings related to its investigations. At a minimum, MCCs shall document the following key actions, including dates and details, for every investigation:

* The information and tip submitted to TennCare OPI and MFCD
* PAL report was checked initially, and quarterly thereafter
* Investigation initiated (including the focus of the investigation)
* Data reviewed
* Sample requested
* Medical records requested
* Medical records received, not received, or received and incomplete
* Medical review initiated
* Medical review completed
* Interviews with members, providers, and/or other relevant individuals
* On-site visits and/or audits
* Overpayment calculated
* Extrapolation calculated
* Communication (written or verbal) with members, providers, and/or other relevant individuals related to the investigation
* Communication with the State, including TennCare, TBI MFCD, AG/MFID, and OIG, if applicable
* Investigation referred to the State
* Investigation returned from the State
* Overpayment notification issued to the provider
* Education issued to the provider
* Pre-payment review implemented
* Follow-up review scheduled
* Investigation closed

Documentation of key actions shall include dates, tracking information and delivery confirmation for mailed communications, and notes or summaries of interviews and other communications. In addition, any written communication or documentation related to the investigation shall be included in the MCC’s investigation case file.

The investigation case file shall include a documented action or a status update at least once every month unless it has been sent as a referral to OPI/MFCD. If a referral has been sent, then a status update shall occur quarterly. If no new actions have occurred in the investigation within the 30-day period, the investigator must document the status of the case and the reason for the lack of actions.

The following is an example of acceptable and unacceptable status updates:

Example: No action has occurred in the investigation due to medical records being under review.

Acceptable: Investigator spoke with the medical reviewer on MM/DD/YY to receive status update. Medical reviewer states that review is approximately 50% complete. Anticipated completion in two weeks.

Unacceptable: Medical records under review.

Additionally, when requesting medical records MCC shall document the following:

* Contact the provider’s office to confirm who should receive the medical records request, confirm mailing address, and confirm the person’s contact information.
* If applicable, requests shall include referring provider records (DME/labs/etc.)
* Submit medical records request via a standard business tracking method that requires a signature such as, USPS return receipt, FedEx tracking, or UPS tracking. The medical records request shall allow no more than thirty days to submit records with the option of an extension if requested.
* If a provider requires a medical records request be sent electronically, it must be documented thoroughly. Requests being sent electronically with no physical receipt have the added responsibility of following up within five business days that the request was received by the designated contact person confirmed in bullet 1.
* When signed return receipt record is returned, ensure the appropriate person signed. If someone else signed the return receipt, follow-up with an email or phone call to the correct person to verify the request was received.
* If the return receipt signature card is not received within two weeks, follow-up shall be conducted.
* If the medical records are not received within thirty days of the initial request, a 2nd request shall be sent within one business week allowing no more than an additional 30 days to submit. It shall be clearly documented on the letter that it is a second request. The letter shall also be sent via a standard business tracking method, and send a copy to any additional people who may have access to the medical records or are in a position of authority – doctor, owner, business manager, etc.
* If the medical records are not received after the second request’s deadline, a follow-up phone call shall be conducted within five business days with the contact for one last verbal request with a specified deadline determined by the investigator.
* If the provider is communicating with the investigator, but all attempts to retrieve the medical records from the provider's office fail, after 60 days OPI should be notified via an Exposure Form and/or added to the monthly call agenda to discuss.
* If there is no communication from the provider, and all attempts to retrieve the medicals from the provider's office fail, the MCC has 30 days to complete all documentation supporting the provider's disregard to submit medical records and submit a referral to TennCare OPI.

All medical record requests shall be thoroughly documented in the CTS, including all calls, letters sent, date mailed, how it was mailed, and copies of the appropriate mailings (return receipt requests, certified mail record, etc.). Ensure the documentation has details of each time the provider was contacted for medical records, and the method used. OPI’s goal with these procedures is to ensure the MCC’s effort of obtaining the medical records is meticulously documented. This information will help determine whether a provider simply overlooked the request or is deliberately ignoring it.

## 2.4 Investigation Timeframe

If an MCC initiates an investigation based on a tip of potential or suspected fraud or abuse, it shall have 270 days to either submit a referral (Appendix F&G) to both OPI and TBI MFCD, or close the investigation and take administrative actions, as appropriate. If the MCC places a provider on pre-payment review prior to initiating a retroactive investigation, the number of days in which the MCC must complete the investigation will be reduced. (See page 34)

The MCC shall report any investigation that will not be completed within the required 270 days to TennCare OPI via email using one of the templates provided in Appendix R. The notification and why the investigation is incomplete shall be documented in the MCC’s investigation case file.

## 2.5 Expedited Referrals

MCCs shall initiate an expedited referral for a provider that is not compliant with medical records requests as outlined in section 2.3, and in some instances, OPI may request for an MCC to submit an expedited referral on an investigation that has not been completed. This typically occurs when TennCare OPI has reason to assume responsibility for the investigation. If TennCare OPI requests an expedited referral, the MCC shall cease all investigation activities and submit a referral form (Appendix F), all documentation related to any medical records request, and all data and information that has been collected and analyzed up to that point. **Following a request for an expedited referral, the MCC shall have 15 calendar days to submit the referral** to OPI **in accordance with the submission requirements outlined in Section 9.1.** The date the expedited referral request was made, as well as the date on which it was sent to TennCare OPI, shall be documented in the MCC’s investigation case file.

Figure 1: Tips and Investigations Timeline 

# **Section 3: Administrative Actions**

Administrative actions may be taken against providers who have been identified as having aberrant and/or potentially fraudulent billing practices. MCCs opting to take administrative action against a provider for program integrity-related reasons shall follow the guidelines below.

## 3.1 Pre-Payment Review

Pre-payment review (also known as a prospective audit/investigation) occurs when a reviewer makes an initial determination on the validity of the claim before it is paid by the MCC. An initial determination of claim validity during pre-payment review does not preclude the claim from post-payment review or audit, which may result in a revised determination.

Pre-payment reviews may be conducted in two ways. First, the MCC’s claims systems shall include pre-payment system edits that perform comparisons on a variety of member and claim factors, such as diagnosis codes, procedures codes, procedure frequency or duration, provider type, and revenue. Pre-payment system edits will automatically deny all or part of a claim, or suspend a claim for further review, if it does not meet the coverage requirements programmed into the claims system.

Pre-payment reviews may also be conducted through analysis of the claims and associated documentation, including members’ medical records. Pre-payment review using this method may occur because of a claim payment being suspended by system edits. An MCC may also require specific providers to undergo pre-payment review for some or all of their claims upon identification of aberrant billing practices.

Providers shall be placed on pre-payment review to correct billing behaviors in need of change and prevent or minimize future financial losses due to inappropriate billing and payment of claims. Other measures, such as corrective action plans and targeted education, shall be used to correct billing errors before initiating pre-payment review, if possible and appropriate. Pre-payment reviews shall not be conducted at the expense of suspected fraud and abuse investigations and/or identification and recovery of overpayments.

Providers shall be removed from pre-payment review as soon as the provider meets the claims submission criteria outlined in the MCC’s policies and procedures. Criteria should be focused on program integrity-related claims issues only.

## 3.2 Pre-Payment Review Policy and Procedure Requirements

TennCare OPI recognizes that, due to the varying organizational structures of the MCCs, policies and procedures for pre-payment review may differ across entities. MCCs that use provider-specific pre-payment review shall have detailed policies and procedures—submitted annually with the organization’s fraud and abuse policies and procedures—which will, at minimum, address the following areas:

* Criteria for placing a provider on pre-payment review
* Determining which of a provider’s codes will be reviewed, including determining when a provider will be placed on 100% pre-payment review
* Notification of initiation of pre-payment review (provider and TennCare OPI);
* Process for conducting pre-payment review
* Provider education to correct identified billing errors
* Initiating retrospective investigations for providers on pre-payment review
* Criteria for escalation and de-escalation of pre-payment review based on:
* Review findings
* Retroactive investigation findings
* Provider referral status
* Criteria for removing a provider from pre-payment review
* Other corrective or administrative actions that may be implemented

## 3.3 Identifying Providers for Pre-Payment Review

The MCCs have the authority to review all claims submitted by a provider; however, due to the volume of claims, provider-specific pre-payment review is usually initiated only when there is the likelihood of sustained or high level of improper billing by a provider. Circumstances in which a provider is identified for pre-payment review include:

* The MCC observes questionable billing practices (e.g., non-covered, incorrectly coded, or incorrectly billed services) through data analysis
* The MCC receives alerts from other internal or external organizations, including quality improvement organizations (QIOs) and recovery audit contractors (RACs), of potential provider fraud and/or abuse
* The MCC receives complaints or tips through its reporting mechanisms

Providers shall not be targeted for pre-payment review for any reason not related to current or ongoing billing concerns with the MCC’s network, such as:

* Previous fraud or abuse allegations or investigations
* Inclusion on the TennCare Provider Alert List (PAL)
* The provider’s specialty or practice type

A MCC may not automatically place a provider on pre-payment review based on their appearance on the PAL; however, the MCC may place a PAL provider on pre-payment review if warranted by data analysis.

When an MCC initiates provider-specific pre-payment review, the provider is required to submit medical records for the selected codes. It is recommended that, initially, the MCC selects codes related to the area(s) of concern. Although MCCs have the discretion to conduct a 100% pre-payment review of a provider’s claims, it shall be noted that CMS considers 100% prepayment review to be appropriate only when a provider has a prolonged period of non-compliance.

## 3.4 Provider Notification of Pre-Payment Review

When initiating a provider-specific pre-payment review, the MCC is required to notify the provider via certified letter with a return receipt or delivery confirmation. The MCC shall maintain a copy of the notification letter and delivery confirmation in the provider’s case/investigation file and shall document the date of notification in the case/investigation notes.

The provider notification letter shall include, at minimum, the following information:

* Requirements for submitting medical records for review
* Person or unit the provider can contact in case of questions
* Reason for initiation of pre-payment review
* Criteria for de-escalation and removal from pre-payment review

If a MCC requires a provider to undergo pre-payment review of claims for specified codes, the MCC shall send the provider a letter or report containing the results of the review and education regarding the appropriate billing requirements for the affected claims within 120 calendar days of the initiation of pre-payment review, unless written approval has been given to extend the 120 days due to the number of records/claims being reviewed. The MCC shall continue to send the provider a results and education letter every subsequent 90 days until such time as the provider is no longer required to undergo pre-payment review. The results and education letter shall include, at a minimum:

* Identification of the provider or supplier—name, address, and NPI
* The reason for conducting the review
* A narrative description of the specific billing issue(s) identified during the review period, as well as any recommended corrective actions
* The review determination for each claim for the specified billing codes, including a specific explanation of why any claims were denied, such as non-covered or incorrectly coded services. If 100% of the provider’s claims are under a pre-payment review, a determination is only required for claims denied
* A list of all individual claims that includes the actual amount denied for each specified claim
* The provider’s or supplier’s right to appeal and information for submitting an appeal request
* A description of any additional corrective actions or follow-up activity the MCC is planning (i.e., continuing, reducing, or discontinuing pre-payment review)
* The MCC’s criteria for reducing or discontinuing the provider’s pre-payment review

## 3.5 Retrospective Review for Providers on Pre-Payment Review

MCCs shall initiate a retrospective medical and coding review of relevant claims for providers on pre-payment review due to suspected fraud and/or abuse, and who are not under active investigation or litigation involving the state or federal government, within 120 calendar days of initiation of pre-payment review. The date of initiation of a retrospective review shall be documented on the *Quarterly Fraud and Abuse Report* in the “MCO Notes” field of the pre-payment review entry. If the retrospective review indicates suspected or confirmed fraud and/or abuse, the MCC shall submit a referral to OPI and TBI MFCD, in accordance with the requirements outlined in Section 9.1. MCCs shall not submit referrals for suspected fraud and abuse based on the results of a pre-payment review or prospective audit/investigation, unless requested by or discussed with TennCare OPI.

If the MCC does not initiate a retrospective review within 120 days of initiation of pre-payment review, the MCC shall document the reason of the *Quarterly Fraud and Abuse Report* in the “MCO Notes” field. The MCC shall document its plan for removing the provider from pre-payment review using corrective or other administrative actions, in accordance with the MCC’s pre-payment review policies and procedures.

## 3.6 Educating Providers on Pre-Payment Review

As pre-payment review is an administrative action intended to correct billing errors, MCCs shall provide targeted education to providers no later than 90 calendar days after pre-payment review is initiated. The MCC shall continue to provide targeted education every 120 days until the provider is no longer on pre-payment review. For more information on targeted education see Section3.9.

## 3.7 Pre-Payment Review for Providers under Investigation

If an MCC submits a referral to TennCare OPI, the MCC may require the provider to continue to undergo pre-payment review of their claims to prevent additional financial losses while the case is under investigation and/or subsequent litigation. MCCs shall provide TennCare OPI with updates on relevant pre-payment review outcomes for providers under state or federal investigation using the *Quarterly Fraud and Abuse Report* (Appendix D).

If OPI returns a suspected fraud and/or abuse referral to the MCC with no action, the MCC should evaluate the provider’s progress in meeting the criteria for removal from pre-payment review, as well as other corrective or administrative actions the MCC may implement to address continued billing errors, in accordance with the MCC’s policies and procedures.

If a provider under investigation voluntarily terminates from the MCC’s network, the MCC shall notify the TennCare OPI Compliance Manager via email within 10 business days. Notification to TennCare shall include the provider’s name, Medicaid ID, NPI, and the reason he was placed on pre-payment review.

## 3.8 Post-Payment (Retrospective) Review

At the conclusion of a post-payment review of a provider’s claims, the MCC shall send the provider a letter or report containing the results of the review and education on the appropriate billing requirements for the affected claims. The results letter or report may be accompanied by a recovery demand letter, if further investigation is not being pursued by the MCC’s SIU or through a referral to TennCare OPI, TBI MFCD, or another appropriate agency. The results and education letter shall include, at minimum (if applicable):

* Identification of the provider or supplier—name, address, and NPI
* Reason for conducting the review
* A narrative description of the overpayment situation that states the specific issues involved in the overpayment, as well as any recommended corrective actions
* The review determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered or incorrectly coded, and if others were payable
* A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, the denied amounts, under/overpayment amounts, and the amounts that will and will not be recovered from the provider or supplier
* Any information required for statistical sampling for overpayment estimation reviews
* Total underpayment amounts
* Total overpayment amounts
* Total overpayment amounts that the provider or supplier is responsible for
* Total overpayment amounts the provider or supplier is not responsible for because the provider or supplier was found to be without fault
* An explanation that subsequent adjustments may be made at cost settlement to reflect settled costs
* An explanation of the procedures for recovery of overpayments, including the MCC’s right to recover overpayments and charge interest on debts not repaid within 30 days
* The provider’s or supplier’s right to request an extended repayment schedule
* The provider’s or supplier’s right to appeal and information for submitting an appeal request
* A description of any additional corrective actions or follow-up activity planned by the MCC (i.e., pre-payment review, re-review in 6 months, etc.)

## 3.9 Targeted Education

Targeted Education is formal instruction(s) directed to a provider by the MCC, which aligns with state and federal guidelines, along with nationally recognized coding organizations such as the American Medical Association, to address specific utilization and billing deficiencies. Deficiencies may be identified through audits, investigations, medical review, high denial rates, billing errors, data analysis, or other means.

The targeted education shall be:

* Specific to the individual contracted provider under investigation/review of addressing what was billed inappropriately or why they are receiving the targeted education (billing or record review, outlier, etc.)
* Provided in the content of the letter with citations to reference. Citations must be set forth within the body of the letter and not solely provided as a link.
* Be informative and direct enough in nature that the contracted provider(s) receiving the education can understand why their claim is deficient, (i.e., medical notes do not support CPT charged, unbundling, etc.) to improve future claims submissions and billing activity.

The instruction given by the MCC to provider(s) shall be addressed and delivered to the *provider* who is under an audit or investigation in a manner that is trackable, and a signature receipt can be verified. These and all communications, whether written or verbal, shall be formally documented in the case management tracking system (name/title/topics/copy of educational letters/return receipt verifications, call summaries, etc.).

## 3.10 Data Mining/Analysis

If data mining or analysis conducted by the MCC identifies a provider who demonstrates aberrant billing practices or who is an outlier for a specific code or service, the MCC may send the provider a notification and education letter regarding the relevant code(s) or service(s). The notification and education letter shall include, at a minimum:

* Identification of the provider or supplier—name, address, and NPI
* The method or type of analysis used to identify the provider’s billing issues
* A narrative description of the specific billing issue(s) identified during data mining or analysis, as well as any recommended corrective actions
* A description of any follow-up activity the MCC may conduct (i.e., additional data analysis, ongoing review of provider’s claims activity)

If the MCC is going to implement a more stringent administrative action, such as conducting a pre- and/or post-payment review, based on the issues identified during data mining or analysis, the MCC does not have to send a notification and education letter to the provider. In this instance, the MCC shall disseminate education to the provider as part of the pre- and/or post-payment review process.

## 3.11 Payment Suspension

Fraud and abuse referrals accepted by TBI MFCD are deemed to be credible allegations of fraud and shall be reviewed by the TennCare PRC. Based on the details and/or severity of the suspected fraud and abuse, the PRC may order the provider to be placed on payment suspension. In the event a payment suspension is ordered, the following steps shall be taken:

* TennCare OPI shall send an initial notice of intent to suspend to each of the MCCs.
* MCCs shall report to TennCare OPI any network adequacy or access to care issues that might be created if the provider was suspended. The initial notice of intent shall include a response deadline for MCCs to provide this information.
* TennCare will evaluate the MCCs’ responses, as well as any other potential impacts of a payment suspension, to determine if the payment suspension process should proceed.
* If it is determined the payment suspension process should proceed, the MCC shall receive a second notice stating that TennCare OPI intends to suspend the provider in five (5) days from the date of the letter.
* TennCare OPI shall send affected MCCs a final decision to suspend notice, stating that payment suspension is effective immediately.
* MCCs shall provide written confirmation within 48 hours to confirm the payment suspension was implemented.

Claims from providers under a payment suspension shall not be processed, adjusted, recouped, or otherwise handled by the MCC until it has received written notification from TennCare OPI that the payment suspension has been lifted.

## 3.12 Documenting Administrative Actions

Review and education notification letters shall be sent to the provider via a trackable method (courier service, certified mail, etc.) to ensure receipt by the provider. The provider’s case tracking file shall include:

* A copy of the letter
* Verification of the method used to send to the provider
* Verification of its receipt by the provider
* A copy of the education letter
* TennCare OPI suspension notice(s)

Administrative recoveries are exempt from being sent by a trackable method.

# **Section 4: Identifying and Recovering Overpayments**

## 4.1 What is an overpayment?

An “overpayment” is defined as the amount paid by a MCC (including DIDD) to a provider which is more than the amount that is allowable for services, and which is required to be refunded. The reasons for Medicaid overpayments may include:

* The recipient of services was not eligible for Medicaid at the time the service was provided
* The MCC made a payment where there was another responsible payer
* The service provided was not covered by Medicaid
* The service provided was covered by Medicaid, but was not medically necessary
* The MCC was the responsible payer, and the service was covered and medically necessary, but the payment was incorrect and exceeded the allowable amount

## 4.2 Overpayments in a Managed Care Environment

As the TennCare program is administered entirely through managed care contractors, which are responsible for paying for services provided to members, the MCCs assume primary responsibility for identifying and recovering overpayments. Effective communication and reporting processes with the State are critical to ensure that overpayments associated with fraud and/or abuse are identified and reported, in accordance with state and federal regulations.

## 4.3 Administrative Overpayments

Overpayments routinely occur in Medicaid and are often the result of an unintentional error or oversight (administrative overpayments). Administrative overpayments may be the result of actions on the part of either the MCC or the provider, including:

* Identification of a responsible third-party payer
* Contract or fee schedule adjustments that affect the payment amounts
* Payment made for services provided to a member after termination of coverage
* Payment made for claims with a date of service after the member’s date of death
* Duplicate payment made
* Incorrect member or provider information
* Data entry error

While termination of coverage may be the result of a loss of Medicaid eligibility or a member changing their MCC assignment, other actions, such as a duplicate claim submitted for payment, may be an attempt at fraudulent activity by a provider. MCCs should be aware of providers demonstrating trends in this area.

## 4.4 Program Integrity-Related (Non-Administrative) Overpayments

While most overpayments are administrative in nature, many are also the result of fraudulent or abusive practices and billing activities by the provider (program integrity-related/non-administrative overpayments). Some provider activities that may result in program integrity-related overpayments include:

* Incorrect reporting of diagnosis or procedure codes to maximize payments
* Altering claim forms, electronic claim records, or medical records
* Unbundling charges
* Misrepresenting the individual who furnished the services
* Billing non-covered or non-chargeable services as covered items

Program integrity-related overpayments also include refunds initiated by a provider who is currently under investigation by TennCare and/or TBI MFCD for suspected fraud or abuse. For processing provider-initiated refunds requirements see Section 9.16.

## 4.5 Identifying Overpayments

The MCC shall have mechanisms in place to identify potential overpayments and providers with abnormal billing patterns in compliance with the CRA or appropriate contract, and shall include, at minimum:

* Fraud and abuse hotline tips
* Provider audits
* Data mining
* Explanation of Benefits (EOB) sampling
* Claims payment accuracy tests
* Automated claims edits
* Provider self-reporting protocols

When a potential overpayment is identified, the MCC shall take the following actions to determine if an overpayment or payment error exists, including:

* Review the claims and associated documentation
* Perform appropriate research regarding liability, covered benefits, TennCare policy, and statutory requirements
* Determine if an overpayment exists and the nature of the overpayment (i.e., program integrity-related, administrative)

If the MCC determines that the overpayment was the result of an administrative or billing error, it shall notify the provider and begin the payment recovery process. If the MCC suspects that an identified overpayment is the result of potential fraud or abuse, it shall utilize its documented methods of investigation to determine if the matter is suitable for referral to TennCare OPI and TBI MFCD, or another appropriate agency. In addition, the MCC shall report all program integrity-related/non-administrative overpayments on the *Quarterly Fraud and Abuse Report* ([Appendix](#_Attachment_B:_Quarterly) D).

A list identifying both administrative and program integrity-related, or non-administrative, overpayment rationales can be found in Appendix A.

## 4.6 Recovering Overpayments

MCCs shall have mechanisms in place for recovering overpayments identified by both the MCC and the provider. These mechanisms shall be described in the MCC’s Annual Compliance Plan submitted to TennCare, and shall include, at minimum:

* Timeframes for initiating recovery following identification of overpayments
* Provider notification of identified overpayments
* Processes and timeframes for the provider to submit identified overpayments
* Actions taken by the MCC for providers that do not respond to or refuse to submit identified overpayments
* Recovering overpayments identified and reported by the provider; and
* Prohibitions on overpayment recovery as outlined in the contract, as well as any prohibitions which may be in place through the MCC’s internal policies

Per T.C.A. 56-7-110, TennCare program MCCs are not restricted to recovering overpayments made to a provider within a certain time frame after the claim has been paid; however, MCCs may choose to implement such a time frame within provider agreements, at their discretion. For example, an MCC provider agreement may state that the entity will not seek recovery of overpayments from the provider more than two (2) years after the date the claim was paid. MCCs shall initiate overpayment recovery on claims associated with referred cases of suspected fraud and/or abuse upon receiving written authorization from TennCare OPI, regardless of whether the claims exceed the MCC’s imposed time frame provision.

## 4.7 Provider Notification of Overpayments

Provider notification of identified overpayments and all recovery attempts must be in a written format and documented in the provider’s file. Written notification and the initial recovery attempt must include, at minimum:

* Name, address, and NPI number of the provider
* Reason for conducting the review/audit resulting in overpayment identification
* Narrative description of specific issues involved in the overpayment, as well as any recommended corrective actions
* The review/audit determination for each claim in the sample, including a specific explanation of why any services were determined to be non-covered or incorrectly billed
* A list of all individual claims that includes the actual non-covered amount, the reason for non-coverage, and overpayment amounts
* Total overpayment amount for which the provider is responsible
* An explanation of the procedures for recovery of overpayments (withhold vs. refunds)
* The provider’s right to appeal the identified overpayments
* The provider appeals process
* The person or unit the provider can contact in case of questions

## 4.8 Prohibition on Overpayment Recovery

As the MCCs are responsible for payments to providers for health care services and supplies, they are entitled to pursue and retain overpayments **except** when the issues, services, or claims upon which the recovery is based meet at least one of the following criteria:

* The overpayment has already been recovered by TennCare or another state agency as part of a resolution of a state or federal investigation and/or lawsuit, including False Claims Act cases and Tennessee Medicaid False Claims Act
* When the issues, services, or claims resulting in the overpayment are currently being investigated by TennCare or another state agency or are the subject of pending federal or state litigation or investigation

If the overpayments have been recovered by TennCare or another state agency as part of a resolution of an investigation and/or lawsuit, the State shall provide written notification of the resolution to the MCC.

Providers who are currently under investigation or who are the subject of pending litigation or investigation are identified on the PAL that is published and shared by OPI on a quarterly basis (Section 7). The MCC shall review the PAL prior to initiating recovery efforts to determine if the provider who accrued the overpayment is the subject of current or pending investigation or litigation. If the provider is listed on the PAL, the MCC shall notify TennCare OPI. The MCC is prohibited from pursuing recovery for program integrity-related or non-administrative overpayments from providers on the PAL until written authorization is received from TennCare OPI or the provider is no longer on the PAL.

In the event the MCC recovers or otherwise obtains funds in cases where overpayment recovery is prohibited, the MCC shall notify TennCare OPI Compliance via email at [ProgramIntegrity.TennCare@tn.gov](mailto:ProgramIntegrity.TennCare@tn.gov) within 10 calendar days and take act in accordance with written instructions from TennCare OPI. If the MCC fails to adhere to the prohibitions related to overpayment recovery, the MCC may be subject to forfeiture of the funds and imposition of liquidated damages.

## 4.9 Overpayment Recovery Following Returned Referrals

MCCs that submit a fraud or abuse referral to TennCare OPI are prohibited from pursuing overpayments on claims related to the case while it is under review or investigation by TennCare OPI, TBI MFCD, and/or AG/MFID. Upon return of a referral to an MCC in which no action was taken against the provider, TennCare OPI will review the matter and may provide written authorization for the MCC to begin overpayment recovery efforts for the related claims. Overpayment recovery shall be initiated by the MCC within 90 days of the date the referral is returned to the MCC. The MCC shall notify TennCare OPI of its progress in recovering the overpayments via the *Quarterly Fraud and Abuse Report* (Appendix D).

Additional information regarding overpayment recovery requirements may be found in Appendix T (TennCare Policy PI 11-001 Overpayments and Section 6402 of the Affordable Care Act).

## 4.10 Reporting Overpayments

MCCs are required to report all program integrity-related/non-administrative overpayments—identified and recovered—to TennCare OPI via the Quarterly Fraud and Abuse Report (see Appendix D) Overpayments reported shall include:

* Overpayments identified and submitted by the provider
* Overpayments recovered after a referral has been returned by TennCare OPI
* Overpayments identified for which recovery is prohibited under the TennCare contract

Annually, MCCs are required to report all recoveries administrative and non-administrative as outlined in Section 9.4.

## 4.11 Provider-Initiated Overpayments

Providers may submit refunds of identified overpayments to MCCs by either 1) sending a check for the overpayment amount, or 2) requesting that the MCC offset future claims until the overpayment amount has been collected. Submission of overpayments shall be accompanied by a completed overpayment refund form, as designated by the MCC, and any required supplemental documentation. The provider-initiated overpayments form must include the following:

* A check to the MCC or state agency for the overpayment amount, or a request that the amount of the overpayment be withheld from future remittances
* Relevant claims data so that the MCC or state agency can identify the point at which the error occurred
* An explanation of how and when the overpayment was identified
* Why the overpayment is being returned

The MCC is required to accept all provider-initiated refunds to be in compliance with federal regulations; and may retain the overpayment returned by the provider using the following guidelines:

* If the refund is less than five-hundred dollars ($500.00) in a 30-day period, the MCC may apply the funds to claims activity. The MCC must be able to account for all provider-initiated refund activity in the event it is later determined that the funds or associated claims are the subject of potential or suspected fraud or abuse.
* If the refund totals five-hundred dollars ($500.00) or more, either individually or cumulatively in a 30-day period the MCC requires the approval of OPI prior to processing.
* All non-administrative/program integrity related overpayments, whether provider initiated or MCO initiated, from providers on the PAL shall not be processed until written approval is received by OPI or the provider is no longer on the PAL.

Additionally, all provider-initiated refunds shall be:

* Reviewed by the MCC for potential fraud, waste, or abuse
* Reported to TennCare OPI on the Quarterly Fraud and Abuse Report.

The MCC may retain the overpayment returned by the provider, unless recovery of the overpayment is prohibited by the contract, as described above, or other TennCare OPI directive. To ensure that it is permissible to retain the overpayment, the MCC shall follow the written direction outlined in Section 9.15, Provider-Initiated Refunds.

Nothing in this section shall be construed to prevent a provider or provider group from submitting unsolicited overpayments directly to the Division of TennCare for services rendered to TennCare members.

## 4.12: OPI Exposure and Removal from PAL Notifications

Exposure notifications to the MCC from OPI are informational in nature to determine if a review of data is warranted. If a review is conducted the MCC will:

* Provide education
* Notify OPI if anything is found worth noting
* Review the provider’s future billing to determine adherence to the education
* The removal from PAL and/or settlement notice is to provide the MCC’s with the scope of affected claims.

# **Section 5: Provider Suspensions, Excluded Individuals and Entities**

42 USC 1320a-7 provides the Secretary of HHS with the authority to exclude various health care providers, individuals, and businesses from participation in federal health care programs. This authority has been delegated to HHS-OIG and the United States. Under 42 USC 1320a-7(a) and (b), exclusions may occur for several reasons, such as conviction of program-related crimes, felony convictions relating to health care fraud and conviction relating to the obstruction of an investigation or audit. For example, there may be a determination that a provider has done one of the following:

* Submitted or caused to be submitted claims or requests for payment under Medicare, Medicaid, or other federal health care programs containing charges (or costs) for items or services furnished substantially more than its usual charges (or costs)
* Furnished or caused to be furnished items or services to patients (whether or not eligible for Medicare, Medicaid, or other federal health care programs) substantially in excess of the needs of such patients, or of a quality that does not meet professionally recognized standards of care

For purposes of exclusion procedures, “furnished” refers to items or services provided or supplied, directly or indirectly, by any individual or entity. This includes items or services manufactured, distributed, or otherwise provided by individuals or entities that do not directly submit claims to Medicare, Medicaid, or other federal health care programs, but that do not supply items or services to providers, practitioners, or suppliers who submit claims to these programs for such items or services.

When an exclusion is imposed, no payment shall be made to the provider for any items or services furnished, ordered, or prescribed by an excluded provider under Medicare, Medicaid, or any other federal health care programs. In addition, no payment shall be made to any business or facility (e.g., hospitals, nursing facilities) that submits claims for payment of items or services provided, ordered, prescribed, or referred by an excluded party.

Generally, decisions made by HHS-OIG or CMS to terminate or exclude providers may not be appealed at the state level. A provider could file an appeal if the ground for the appeal is that the State has mistakenly confused the appealing provider with the actual provider excluded by OIG. Any opportunity for a provider to file an appeal at the state level would have occurred prior to the decisions by HHS-OIG or CMS to terminate or exclude the provider and only if the investigative or disciplinary action had been initiated by the State.

## 5.1 Prohibition on Employing or Contracting with an Excluded Individual or Entity

Section 6501 of the Affordable Care Act, codified in 42 CFR 455.416(c), requires that state Medicaid agencies deny enrollment or terminate enrollment of any provider who has been excluded on or after January 1, 2011, under Medicare, Medicaid, or other federal health care programs. To comply with these requirements, TennCare CRAs and policies must include the following provisions:

* MCCs shall not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or other federal health care programs, or who are not in otherwise good standing with the TennCare program
* MCCs, as well as their contractors and providers, whether contract or non-contract, shall not employ individuals who have been excluded from participation in the Medicare, Medicaid, and/or other federal health care programs, or who are not in otherwise good standing with the TennCare program
* MCCs, as well as their contractors and providers, whether contract or non-contract, shall conduct exclusion screenings on all employees and subcontractors upon contract or hire, as applicable, and monthly thereafter
* MCCs shall conduct exclusion screenings of its providers, contractors, owners, and agents monthly

The MCC shall have provisions in its fraud and abuse compliance plan regarding performing exclusion screenings for its owners, agents, employees, providers, and subcontractors, initially and on an ongoing monthly basis against the HHS-OIG LEIE, GSA SAM, and TennCare’s Terminated Provider List. Each MCC shall submit a monthly Program Integrity Exception Report to TennCare OPI (Section 9.7).

In addition, the MCC’s provider and contractor agreements shall include provisions requiring the providers and contractors to conduct monthly exclusion screenings on their employees and subcontractors, initially and on an ongoing monthly basis. MCCs shall have provisions in place to ensure providers and contractors are conducting initial and monthly exclusion screenings for their employees and subcontractors, as well as the providers’ and contractors’ requirements for reporting individuals identified as excluded from participation in Medicare, Medicaid, or other federal health care programs.

## 5.2 Denial of Payment to Excluded Individuals or Entities

MCCs shall not make payment to any excluded individual or entity for items or services furnished, ordered, or prescribed in any capacity on or after the effective date of exclusion. However, in some instances, an excluded physician may have a salary arrangement with a hospital or clinic, or work in a group practice, and may not directly submit claims for payment. If this situation is detected, the MCC shall report the case to TennCare OPI within five (5) business days and await written direction from TennCare OPI prior to taking any further actions.

Any payments made to a provider, contractor, or subcontractor after the effective date of exclusion are considered overpayments and are subject to recoupment in accordance with procedures outlined in TennCare Policy # PI 11-001 regarding overpayments (see Appendix U). MCCs shall have policies and procedures in place for recoupment of payments made to contractors and providers after the effective date of exclusion.

## 5.3 Tennessee’s Exclusion List on website

MCCs are required to screen their owners, agents, employees, providers, and subcontractors initially and an ongoing monthly basis against TennCare’s Terminated Provider List located at:

<https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html>

## 5.4 Suspensions

When a provider or group requires payment suspension, TennCare will send notice of TennCare’s Decision to Suspend Payments to the MCC. The suspension shall be implemented within 2 business days. If a provider group payment suspension is requested, no payments shall be made to the provider group, or to any individual provider within the group for services rendered on behalf of the suspended provider group. If an individual provider’s payments are suspended, no payment shall be made to that individual, or for any services rendered by that individual.

While these two examples are the majority of payment suspension scenarios, there may be other circumstances which will be clarified in the payment suspension notice. In all circumstances, unless written approval has been received from the TennCare OPI Director or Legal Officer, no deviations from the payment suspension notice shall be made. Any questions regarding the implementation of a payment suspension should be directed to the OPI Legal Officer.

# **Section 6: Provider Subcontracting**

The MCC shall have provisions in its provider agreements, and all provider agreements executed by subcontracting entities or organizations, that prohibit the provider from entering into a subcontract with an individual or entity for the purposes of providing TennCare-covered services without obtaining written approval from the MCC.

Claims submitted by the unapproved subcontractor, or by the provider for services furnished by the unapproved subcontractor, are considered improper payments and may be considered false claims. MCCs shall evaluate tips of claims submitted by or on behalf of unapproved subcontractors and conduct investigations—including provider site visits, if necessary and appropriate—to verify if the provider is utilizing an unapproved subcontractor.

# **Section 7: Provider Alert List**

Each quarter, TennCare OPI distributes a PAL report which identifies the names and NPIs, if available, of providers and provider groups that are currently under investigation or litigation by the State—TennCare OPI, TBI MFCD, and/or AG/MFID—for suspected fraud or abuse. The PAL is sent to all MCCs via email and is uploaded to the SFTP server by the 15th day following the end of each quarter. The PAL report shall be used by investigators to ensure a provider is or is not listed on the PAL by:

* Reviewing all cases at a minimum each quarter to the PAL report
* Reviewing the PAL report prior to starting an investigation

Investigators shall make appropriate notes in the case tracking system stating the PAL report was reviewed. **MCCs shall notify OPI within ten business days of any discrepancies in the PAL report.**

Monthly, no later than the 5th of each month, OPI will distribute updates to the quarterly PAL report which will include cases that have been closed or added since the last quarterly PAL report was distributed. The monthly report is solely to be used as a reference for cases opened by the State prior to the next quarterly report.

MCCs may add fields to the PAL (such as the TIN) and/or distribute the spreadsheet to additional personnel or units working under the TennCare line of business, as it deems appropriate. MCCs shall not distribute the confidential PAL or share in any manner the contents of the list outside of its TennCare line of business. If an MCC receives a request from an individual or entity outside of its TennCare line of business—including other lines of business under the MCC—to obtain a copy or review the contents of the PAL, it shall direct the requestor to contact TennCare OPI. The MCC shall also notify TennCare OPI that a request was received.

MCCs may pursue providers on the PAL in their commercial and Medicare markets.

7.1 Provider Alert Restrictions

If a provider’s name and NPI are identified on the PAL, MCCs shall not conduct any investigative activities or non-administrative recoveries against that provider—without written authorization from TennCare OPI—including:

* Medical records requests
* On-site or desk audits
* Provider interviews
* Overpayment recoveries

MCCs may recover overpayments for accepted administrative reasons, such as third-party liability or fee schedule changes. A list of accepted administrative reasons may be found in [Appendix](#Appendix_6_Admin_PI_Overpayments) A. MCCs must receive written permission from TennCare OPI prior to recovering an overpayment for reasons other than those listed.

If the provider whose name and NPI are identified on the PAL practices in a group, and that group name and NPI are not identified on the PAL, the group and its other providers are subject to investigative or recovery activities, as deemed necessary by the MCC.

Example 1: Dr. Smith’s name and NPI are identified on the PAL; therefore, the MCC shall not conduct any investigative activities or non-administrative recoveries against Dr. Smith.

Example 2: Dr. Smith’s name and NPI are identified on the PAL. Although Dr. Smith practices at The Good Care Clinic, he bills under his own NPI. The Good Care Clinic and its NPI are not identified on the PAL. The MCC may not conduct investigative activities or non-administrative recovery activities against Dr. Smith; however, it may conduct such activities against the clinic and any other providers in the practice.

If a group name and NPI appear on the PAL, MCCs shall not conduct any of the above listed investigative activities or non-administrative recoveries against any providers that bill under the identified NPI; however, providers practicing within the group listed on the PAL and billing under their own NPI are still subject to investigative or recovery activities, as deemed necessary by the MCC.

Example 3: The Good Care Clinic and its NPI are identified on the PAL. All providers at The Good Care Clinic bill under the clinic’s NPI. The MCC shall not conduct investigative activities or non-administrative recoveries against any provider at The Good Care Clinic.

Example 4: The Good Care Clinic and its NPI are identified on the PAL. Dr. Smith and Dr. Jones bill under the clinic’s NPI. However, Dr. Wright, who also practices at The Good Care Clinic, bills under his own NPI and is not identified on the PAL. The MCC shall not conduct investigative activities or non-administrative recoveries against services provided by Dr. Smith or Dr. Jones but may conduct such activities against Dr. Wright.

If a provider billing under a group name and NPI that appears on the PAL leaves and begins billing under a new group and NPI (not identified on the PAL), the provider is subject to investigative activities and non-administrative recoveries for claims submitted under the new group.

Example 5: The Good Care Clinic and its NPI are identified on the PAL. Dr. Jones, who was billing under the clinic’s NPI, leaves the practice and joins the Fast Health Clinic. The Fast Health Clinic and its NPI are not identified on the PAL. The MCC may conduct investigative activities and non-administrative recoveries against Dr. Jones for services provided at the Fast Health Clinic.

# **Section 8: Communications Management**

## 8.1 Monthly Calls

An MCC shall host scheduled monthly calls with TennCare OPI to maintain ongoing communication between on-site fraud and abuse meetings, as well as discuss specific program integrity-related questions and concerns. Topics to address during monthly calls may include:

* Current investigations
* Pending referrals
* MCC contract requirements
* TennCare or MCC policies

### 8.1.a Scheduling

MCCs are responsible for sending the monthly meeting invite to TennCare OPI, as well as the internal personnel whose attendance is requested and/or required. For ease of scheduling, it is suggested that MCCs reserve the same day and time each month using a recurring meeting invite (e.g., the third Monday of every month at 2:00 pm). TennCare OPI reserves the right to forward the meeting invite—for either the recurring meeting or an individual meeting—to other individuals, TennCare units, and/or law enforcement agencies, as it deems appropriate.

The monthly calls may be rescheduled or canceled by the MCC or TennCare OPI, as needed, due to availability of participants or lack of agenda items. While TennCare OPI understands that circumstances may require a change or cancellation with little notice, it is requested that notice is provided to other invitees at least two (2) business days prior to the scheduled call, when possible.

### 8.1.b Agenda

**MCCs are responsible for developing the agenda for the monthly call** and shall **distribute it** to TennCare OPI and other relevant participants **at least two (2) business days prior to the scheduled call.** TennCare OPI will notify the MCC of any additional topics or agenda items, if applicable. A Monthly Call Template is provided in Appendix T, or the MCC may use one of its own.

### 8.1.c Case Review

MCCs **shall complete the *MCC Audit Exposure* form (Appendix Q) for each open case or investigation they are considering referring and would like to discuss on the call.** The form(s) shall be submitted via email to TennCare OPI **at least two (2) business days prior** to the scheduled call and attached to the meeting invite. The MCCs shall be prepared to discuss the information contained on the form in detail so OPI can render an informed decision.

Tip and Audit updates do not need to be updated during the monthly meetings unless pertinent information or questions have arisen during the investigation.

If the MCC does not have the requested case information available, TennCare OPI may elect to postpone discussion of the case until such time the MCC is sufficiently prepared.

### 8.1.d Meeting Documentation

The MCCs and TennCare OPI will each be responsible for taking notes on discussions and/or activities that occur during the monthly call and disseminating the information to other individuals or divisions internal to their organizations, as appropriate.

### 8.1.e Meeting Follow-up

The MCCs and TennCare OPI shall each provide responses to any requests for information posed during the monthly call within the timeframes agreed upon by both parties.

## 8.2 Quarterly Fraud, Waste, and Abuse Meeting

TennCare OPI shall host quarterly meetings for each MCC to discuss the contents of the *Quarterly Fraud and Abuse Report* (QFA Report) submitted for the prior reporting period.

### 8.2.a Participants

Meetings shall include members of TennCare OPI, TBI MFCD, OIG, and AG/MFID, as well as relevant subject matter experts (SME), as determined necessary by the State.

At minimum, MCCs shall be represented at the meetings by the Compliance Officer and SIU Manager. If one or both individuals are unable to attend, a designated individual(s) shall attend in their place. Designated individuals attending in place of the required personnel must be able to provide information and respond to questions related to the meeting agenda, including fraud and abuse tips and investigations and the MCC’s program integrity-related policies.

At their discretion, MCCs may have additional personnel participate in the meeting, in person or virtually, such as SIU investigators or SME, as necessary and appropriate.

### 8.2.b Agenda

TennCare OPI will develop each MCC’s agenda based on the contents of the QFA Report and send it out to the MCC prior to its scheduled meeting date. Agenda items may include:

* Reported tips and audits
* Pending and/or submitted referrals
* Overpayments recovered (provider- and MCC-initiated)
* Follow-up on outstanding tips and audits from previous on-site meetings/reports
* Program integrity-related administrative actions taken by the MCC, including pre-payment review
* Provider education (general and targeted)
* Providers on the PAL
* TennCare policy and procedure updates
* CMS policy and guideline updates
* Updated CPT/HCPCS coding guidelines

The agenda will include time for representatives from TBI MFCD, OIG, and AG/MFID to ask questions of and/or provide information to MCCs related to fraud and abuse investigations, referrals, and program integrity-related policies and procedures.

MCCs shall be given—and are strongly encouraged to use—time during the meeting to discuss and/or ask questions about program integrity-related topics, including:

* Ongoing investigations
* Pending referrals
* TennCare and MCC policies and procedures
* Data analysis projects
* New initiatives for preventing, identifying, and/or investigating potential or suspected fraud and abuse

TennCare OPI will send an email to the MCCs requesting any items or topics they wish to add to the agenda. MCCs shall respond with any additional items or topics by the date specified in the email. TennCare OPI prefers to receive information on additional agenda topics prior to the scheduled quarterly meeting to conduct any necessary research, or prepare responses or questions, prior to the meeting; however, MCCs may still discuss additional items during the quarterly meeting if the topics have not been submitted to TennCare OPI beforehand. The agenda will be sent to the MCCs via email prior to the scheduled meetings to ensure relevant personnel will be available to respond to agenda items.

### 8.2.c Meeting Minutes

TennCare OPI shall take meeting minutes on the agenda form to capture information, responses, and outstanding questions regarding each agenda item. TennCare OPI shall send MCCs a draft copy of the minutes via email following the meeting. MCCs shall respond to the meeting minutes with any additional relevant information and responses to outstanding questions. MCC responses shall be due by the date indicated in the email—approximately two (2) weeks following distribution of the draft minutes. TennCare OPI shall finalize and forward the quarterly meeting minutes with the MCC’s revisions, if any, within 30 days of the quarterly meeting.

## 8.3 Office of Program Integrity Semi-Annual Meeting

The Office of Program Integrity hosts bi-annual Fraud, Waste or Abuse meetings to share information on new trends or issues that benefit the other participants.

### 8.3.a Participants

These meetings are attended by all MCCs, TBI, OIG, DOH, OPI, TennCare staff, and other state agencies.

### 8.3.b Agenda

The meeting agenda varies, but normally includes general discussions, a guest speaker, and current issues.

### 8.3.c Minutes

No formal minutes are captured, but any meeting presentations with the group may be shared, subject to confidentiality issues.

## 8.4 Office of Program Integrity Inservice Training

The Office of Program Integrity hosts an annual in-person Summit. The conference will be coordinated by OPI staff and be a collaborative effort with the MCCs and state partners. The agenda will be created from suggested content and ideas submitted by the MCCs, and state partners. All TennCare LOB staff related to FWA is expected to be in attendance. This Summit is separate and apart from the semi-annual Fraud, Waste and Abuse meetings where MCC attendance is also required.

### 8.4.a Participants

These meetings are attended by all MCCs, TBI, OIG, DOH, OPI, TennCare staff, and other state agencies.

### 8.4.b Agenda

The agenda will be provided by OPI Compliance prior to the conference.

### 8.4.c Minutes

The attendees will share applicable meeting presentations.

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# **Section 9: Contract Deliverables**

This section outlines all contract deliverables, submission guidance, and detailed reporting requirements required by OPI. Table 1 provides an overview of all reports and the entities that are required to submit each report. **MCC reports shall include CoverKids, and Katie Beckett information where appropriate.** TOPS= TennCare Oversight Processing System.

Table 1: Contract Deliverables

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Deliverable | Filename Naming Convention | Due Date | Delivery | UHC | AGP | BC | TCS | ORx | DQ | DIDD | CDTN |
| 9.1 | [MCC Referral Form and Checklist Form](#_9.1_Referrals_for)  Amended MCC Referral Form/Checklist/Folders | MCC Provider Name YYYY MM (zip file)  MCC Provider Name YYYY MM Amended | As needed | SFTP |  |  |  |  |  |  |  |  |
| 9.1a | Draft Referrals | MCC Provider Name YYYY MM | As needed | Email |  |  |  |  |  |  |  |  |
| 9.2 | Annual Fraud, Waste, and Abuse Compliance Plan | YYYY MCC Compliance Plan | March 1 | TOPS |  |  |  |  |  |  |  |  |
| 9.3 | Annual Deficit Reduction Act Policies/Procedures | YYYY MCC DRA Policies | Ad hoc | TOPS |  |  |  |  |  |  |  |  |
| 9.4 | Annual Recoveries | YYYY MCC Annual Recoveries | February 15 | TOPS |  |  |  |  |  |  |  |  |
| 9.5 | Annual Summary Results of FWA Tests Performed | YYYY MCC Annual Summary FWA tests | Ad hoc | TOPS |  |  |  |  |  |  |  |  |
| 9.6 | Monthly Tips | YYYY MM MCC TIPS | By the 5th of each month | SFTP |  |  |  |  | TOPS |  |  |  |
| 9.7 | Monthly Program Integrity Exception List | YYYY MM MCC Exceptions | By the 20th of each month | TOPS |  |  |  |  |  |  |  |  |
| 9.8 | Summary Report- All Programs | YYYY XQTR MCC Summary Report | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |
| 9.9 | Annual PCS Audit Results | YYYY MCC Annual PCS Audit Results | March 31 | TOPS |  |  |  |  |  |  |  |  |
| 9.10 | Annual 42 C.F.R. Part 455, Subpart B Attestation | YYYY MCC Annual 42CFRPart455 Attestation | March 31 | TOPS |  |  |  |  |  |  |  |  |
| 9.11 | Quarterly Fraud, Waste, and Abuse Activities | YYYY XQTR MCC FWA Activities | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |
| 9.12 | Intentionally Left Blank | N/A | N/A | N/A |  |  |  |  |  |  |  |  |
| 9.13 | Quarterly Utilization Outlier | YYYY XQTR MCC Utilization Outlier | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |
| 9.14 | Quarterly Cost Savings | YYYY XQTR MCC Cost Savings | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |
| 9.15 | Provider-Initiated Refunds | Provider Name PI Refund YYYY MCC | By the 15th of each month | TOPS |  |  |  |  |  |  |  |  |
| 9.16.1 | Request for Information | RFI Number RFI Name MCC | OPI tool as needed | TOPS |  |  |  |  |  |  |  |  |
| 9.16.2 | On Request Reports | ORR Number ORR Name MCC | OPI tool as needed | TOPS |  |  |  |  |  |  |  |  |
| 9.17 | MCC Audit Exposure Form | Provider Name YYYY MM MCC | Monthly meetings | Email |  |  |  |  |  |  |  |  |
| 9.18 | Quarterly Denied Provider Credentialing Summary | YYYY XQTR MCC Denied Provider Credential | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |
| 9.19 | Notification of Investigation Exceeding 270 Days | Subject: YYYY MM MCC Exceeding 270 Days | By the 20th of each month | Email |  |  |  |  |  |  |  |  |
| 9.20 | Non-Registered Provider Payments | YYYY XQTR MCC Non-Reg Provider Payments | 30 days after quarter end | TOPS |  |  |  |  |  |  |  |  |

## General Deliverable Instructions

1. If a report due date falls on a weekend or holiday, submit the report the next business day.
2. All templates will contain a revision date to the right of the title, use the template that correlates to the latest MCPIM version. For example, the revision date will state either “effective 1/1/20xx or effective 7/1/20xx”.
3. File naming conventions shall be used, or the deliverable will be returned with a request to change the name.
4. The guidelines outlined below for each deliverable serve as a general overview for the MCC when completing the required report; however, these guidelines may not cover all instances that may arise, and any additional questions should be directed to OPI Compliance for further instruction.

### Filename Naming Convention Instructions

1. Definitions of naming conventions
   1. YYYY = 4-digit year
   2. MM = Use a 2-digit format for month (May=05)
      1. For **recurring reporting**, the **month used** should reference **when the information was submitted to MCC, not the month the information is being submitted to TC**
      2. For referrals and the 270 Day report the month used should reference when the referral or 270 Day report is being submitted to TC
   3. X QTR= Use the quarter that the information pertains to, **NOT** the quarter the deliverable is being submitted to TC
   4. MCC = MCC abbreviation (UHC, AGP, BCT, TCS, DIDD, ORx, DQ, PPL)
   5. Do not use dashes or underscores in the filename
2. Do not use additional subfolders under main deliverable folder unless instructed (i.e., referrals) we are unable to open files when the file length, including folder names are over 255 characters.
3. Use the naming convention in Table 1: Contract Deliverables
4. If a provider being referred is a MAT provider add “MAT” to the end of the referral name

### SFTP Folder Instructions

1. Delete any empty folders on the SFTP server
2. Create a folder for each deliverable then create folders for each year under the deliverable folder, for example:

Tips Report

2020

2021

2022

1. For referrals, create a folder called Referrals, then create a folder for each year under the Referral folder, as referrals are added create a folder with the name of the provider the referral is for to place the referral information, for example:

Referrals

2020

Betty Boop

Bugs Bunny

Michigan Frog

2021

Keebler Elf

Marvin Martian

Daffy Duck

## 9.1 Submitting Referrals for Suspected Fraud and Abuse

### 9.1.a Draft Referral

* A draft referral form (only) in Word format shall be submitted to the OPI Compliance Manager, Investigations Manager, and the MCC’s respective Compliance Officer via email prior to submitting all referral folders and uploading to the SFTP.
  + When emailing to OPI the subject line should contain “*MCC Draft Referral - Provider Name”*
  + OPI will review the draft and respond to the MCC within 10 business days for any outstanding questions or comments via track changes.
  + Once OPI returns the draft referral back to an MCC:
    - Requests for a referral must be submitted within 20 days, and the information shall be included in the Quarterly Fraud and Activities Report Referral tab.
    - If a draft referral is denied then a referral is not needed, and the draft referral should not be reported on the Quarterly Fraud and Activities Report Referral tab.

### 9.1.b Instructions for Submitting Referrals

Referrals shall be submitted through the TennCare SFTP server as needed or when requested by TennCare OPI. The referral should be a finalized copy and not the draft with tracked changes.

The referral shall:

1. Include:
   1. Referral form: contains information that supports a credible allegation of fraud
   2. Referral Checklist: ensures all required referral documentation is submitted
   3. Related folders: a folder for each line item in the Checklist must be included with the Referral, whether it contains files or not
2. Be submitted as a zip file which shall include all documentation and folders
3. Utilize the following Naming Conventions
   1. Zip files: MCC YYYY MM Provider Name
   2. Folders: Name and Number according to the line items in the Checklist “Folder

Number Name.” Every checklist line item should have a matching folder

* 1. Documents: Provider Last Name Document Content
  2. Do not exceed 255 characters including the path, folder, and filename

1. Transferring the zip file to TennCare OPI and TBI MFCD
   1. Submit the zip file using the TennCare server paths:
      1. /tncare/MCC###/orr/opi/in
      2. /tncare/MCC###/orr/tbi/in
   2. Notify TennCare OPI and TBI MFCD by email that a referral was submitted. Place “MCC### Notice of Referral Submission - Provider Name” in the subject line
2. Amended Referrals
   1. Only submit folders that include new or revised information in the zip file
   2. The zip file, filenames, and folders shall include “amended” after the required naming convention outlined above

When notifying TennCare OPI and TBI MFCD add, “MCC### Notice of Referral Submission Amendment – Provider Name”.

### 9.1.c Referral Requirements

The following identifies each of the required folders to be transferred to OPI via the SFTP server and describes the documentation to be included in each folder.

1. **Referral Form and Checklist**

The MCC shall submit the TennCare OPI referral form and checklist for all referrals. Both documents must be filled out completely. If there are sections or fields on the forms that the MCC is unable to complete, the MCC **shall include a comment as to why the section or field is blank.**

1. MCC Referral Form

The referral form (Appendix F) shall contain pertinent information that supports a credible allegation of fraud. MCC Referral Document Checklist (checklist)

* The checklist (Appendix G) is used to ensure that the MCC is submitting all required referral documentation.

## 9.2 Fraud, Waste, and Abuse Compliance Plan

Each MCC is required to submit an annual Fraud, Waste, and Abuse Compliance Plan (Plan) and crosswalk (Appendix J). An electronic copy of the Plan shall be provided to TennCare OPI within ninety (90) calendar days of the MCC’s contract execution date, and annually thereafter via TennCare’s tracking tool.

OPI shall provide notice of approval, denial, or modification to the MCC within forty-five (45) calendar days of the due date. The MCC shall make any requested updates or modifications to the Plan available for review, as requested by TennCare OPI, within 30 calendar days of the request. The elements listed below are required of all entities (MCOs, PBM, and DBM) unless otherwise noted. The compliance plan shall include supporting documentation of policies and procedures in place. For instance, to document the education of providers and employees the MCC shall submit, at a minimum, any training policies, the employee and provider manual, training schedule for the upcoming year, how training is tracked, and presentation(s) or an outline of training content.

When submitting the compliance plan documents, each MCC shall:

* Ensure standalone documents are submitted, not one PDF containing all the documents
* Label all documents with the section letter it is supporting (i.e., C1- Training Schedule), if the document supports several sections use the first section number, the document was introduced in the file syntax; examples are included in the Compliance Crosswalk, (Appendix J).
* When referring to page numbers, ensure the page numbers are saved in the pdf itself and not a screen page number that may change
* Ensure the section(s)/policy clearly states how it supports the requirement

**The Compliance Plan shall:**

1. **Provide information on how the MCC meets the requirements of reporting** suspected and/or confirmed fraud and abuse as required by the contract, and Federal and State laws and regulations. It should outline the organizations’ policies and procedures for detecting and preventing all areas of FWA.
2. **Include a risk assessment of the MCC’s various fraud and abuse/program integrity processes.** Include a risk assessment of the MCC’s various fraud, waste, and abuse/program integrity processes. A risk assessment shall also be submitted on an ‘as needed’ basis and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines), is issued on a provider with concerns of fraud, waste, and abuse. The MCC shall inform TennCare OPI of such action and provide details of such financial action. The assessment shall also include a listing of the CONTRACTOR’s top three vulnerable areas and shall outline action plans in mitigating such risks.

**It is required that the top three (3) FWA risks** identified in the assessment be included in the MCC’s Plan; however, the MCC may include information regarding additional identified risks or the full results of the assessment, at its discretion. The top three (3) FWA risks shall be accompanied by a description of the MCC’s mitigation plans, which may include education, monitoring, auditing, and/or policy implementation. It shall also identify the owner (individual or division) of the risk and mitigation plan(s).

1. **Outline activities for the reporting year regarding employee education of federal and state laws and regulations related to Medicaid program integrity against fraud, waste, and abuse training to ensure that all the MCC’s officers, directors, managers, and employees know and understand the provisions of the MCC’s Plan.**

The MCC’s Plan shall indicate how it plans to meet state and federal requirements for providing education related to compliance and fraud, waste, and abuse to its officers, directors, managers, and employees. The MCC shall provide a calendar which lists education and/or training sessions that will be provided, the timeframe (month/year) and/or frequency (e.g., annually, quarterly, as needed) that the education will be provided, and the education or training’s audience (e.g., new hires, all employees, managers). It shall also include information about any specialized or targeted trainings related to compliance and/or prevention, detection, or investigation of fraud, waste, and abuse provided by the MCC to its officers, directors, managers, and employees.

1. **Outline activities proposed for the next reporting year regarding provider education of federal and state laws and regulations related to Medicaid program integrity against fraud, waste, and abuse, as well as activities for identifying and educating targeted providers with patterns of incorrect billing practices and/or overpayments.**

The MCC’s Plan shall indicate how the MCC will:

* Meet state and federal requirements for providing education related to compliance and fraud, waste, and abuse to its providers. The Plan shall describe the education that is provided, the method(s) of providing education, and the number of times and/or frequency in which education is provided.
* Describe how the MCC intends to provide targeted education to providers with patterns of incorrect billing practices and/or overpayments. The Plan shall describe the method(s) of providing targeted education, the type(s) of information provided in the targeted education, and how incidents of targeted education are documented in the provider’s file.
* Describe how the MCC provides information and/ or training on medical, dental, and pharmaceutical record standards including cloning medical notes and possible consequences.

1. **Outline unique policies and procedures, and specific instruments, designed to identify, investigate, and report fraud, waste, and abuse activities under the CHOICES program. (Applies to the statewide MCOs only)**

The MCO’s Plan shall identify and/or include a description of all policies, procedures, and/or instruments used to detect, investigate, and report fraud and abuse activities under the CHOICES and ECF CHOICES programs, including personal care services and consumer directed care services. This may include:

* Generating/receiving tips
* System edits designed to identify aberrant billing activity specific to CHOICES services
* Documentation reviews
* Site visits
* Audits (desk or on-site)
* Member interviews
* Agency/provider credential verification

1. **Contain procedures designed to prevent and detect fraud and abuse in the administration and delivery of services under the contract.**

The MCC’s Plan shall identify processes, actions, and/or steps taken by the organization to prevent and detect fraud and abuse, both within the organization and by providers, vendors, and/or members. Prevention and detection procedures may include:

* Training
* Credential verification
* Employee and provider screenings
* Pre-payment review
* Audits (desk and on-site)
* Site visits (announced and unannounced)

1. **Include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:**
2. A list of automated pre-payment claims edits

OPI recognizes that MCCs may apply hundreds of claims edits to each claim prior to adjudication; therefore, a complete list of all pre-payment claims edits is not required. Compliance with this requirement may be met with the provision of other information:

* A partial list of pre-payment claims edits used
* Policies related to the MCC’s use of pre-payment claims edits
* A list of error and/or warning message prompts that are triggered by pre-payment claims edits

1. A list of automated post-payment claims edits

The MCC’s Plan shall provide a list of post-payment claims edits, algorithms, reports, and/or policies used to detect potential or suspected fraud and abuse following claims adjudication.

1. A list of desk audits on post-processing review of claims

The MCC’s Plan shall identify and describe the types of desk audits conducted by the MCC following claims adjudication.

1. A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews

The MCC’s Plan shall list and briefly describe all reports used to 1) determine if providers are eligible for payment of claims for Medicaid services, and 2) identify providers displaying aberrant billing patterns. This shall include reports generated at the time of initial credentialing, re-credentialing, and/or on an ongoing basis, as applicable. Examples of reports that may be listed include the Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE), Program Integrity Exception Reports, background checks, provider outlier reports, and/or code frequency reports.

1. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services

The MCC’s Plan shall list and briefly describe the surveillance and utilization management processes in place to prevent and detect potential or suspected fraud and abuse, which may include:

* Medical necessity reviews
* Prior authorizations
* Use of cost-effective alternatives
* Pre-payment review
* Utilization reports

1. A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials

The MCC’s Plan shall list the specific provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials. The list of provisions shall include the item/section number and content of each provision.

1. A list of references in provider and member materials regarding fraud and abuse referrals

The MCC’s Plan shall list specific references in provider and member materials regarding the reporting of potential or suspected fraud and abuse. The list of references shall include identification of specific section or item numbers and a summary of the content for each reference. Materials to be referenced include:

* Provider manuals
* Member handbooks
* Provider and member newsletters
* Provider and member pages on the MCC’s website(s)

1. **Include a list of provisions for the confidential reporting of Plan violations to the designated person at the MCC.**

The MCC’s Plan shall identify the methods available to its employees for the confidential reporting of potential or suspected fraud and abuse and/or violations of provisions in the Plan. The Plan shall also identify the individual(s) designated to receive these reports.

1. **Include a list of provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports.**

The MCC’s Plan shall provide a list of provisions for conducting investigations and follow-ups of suspected or confirmed fraud and abuse and/or violations of provisions of the Plan. Provisions shall consist of detailed descriptions of the investigative and follow-up processes utilized by the MCC, as well as identify the personnel or units involved. The MCC may include or attach its investigation policies and/or procedures to the Plan, in lieu of listing the provisions; however, the policies and/or procedures must include detailed process steps and identify personnel or units involved, in order for the Plan to be compliant with this requirement.

1. **Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating fraud, waste, and abuse compliance plan violations.**

The MCC’s Plan shall include the organization’s policies and/or procedures that direct officers, directors, managers, and employees in the detection, reporting, and investigation of fraud and abuse compliance plan violations, both internal and external to the organization. The MCC may choose to include the actual procedure documents, or to identify the specific policies and/or procedures and provide detailed summaries.

1. **The Plan shall require reporting of the following:**

The MCC’s Plan shall clearly state that any:

* Suspected provider fraud and abuse will be reported simultaneously to TBI MFCD and OPI.
* Suspected enrollee fraud will be reported to Tennessee OIG.
* Allegations of potential or suspected patient neglect, physical and/or sexual abuse, and financial exploitation of any members will be reported to TBI MFCU.

1. **Ensure that the identities of individuals reporting violations of the MCC are protected and that there is no retaliation against such persons.**

The MCC’s Plan shall identify and describe the policies, procedures, and/or mechanisms for ensuring that no individual who reports:

* MCC violations
* Suspected fraud and abuse
* Enrollee fraud or abuse, or
* Suspected patient neglect, physical and/or sexual abuse, and financial exploitation of any member is retaliated against. Reporting individuals may include MCC employees, providers, provider employees, and members.

1. **Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.**

The purpose of this requirement is for the MCC to proactively review provider types or specialties determined to be at high risk of committing fraud and abuse. The MCC’s Plan shall identify the types of providers defined as high risk, describe the methodology for selecting which providers will receive site visits and/or field audits, and specify the number of site visits and/or field audits it plans to conduct. The Plan shall also identify the type(s) or methodology(ies) of its planned audits and the activities or trainings conducted by the MCC’s employees during announced and unannounced site visits and/or field audits.

1. **Shall have provisions regarding compliance with the applicable requirements of the Model Compliance Plan for Medicaid MCOs or Medicare+Choice Organizations/Medicare Advantage plans issued by Department of Health and Human Services OIG.**

The MCC’s Plan shall identify the seven requirements of the “Model Compliance Plan for Medicaid MCOs” and describe how the organization’s Plan addresses each requirement.

1. **The Plan shall provide a list of procedures regarding implementation of TennCare policy on disclosure and adverse action reporting.**

The MCC’s Plan shall describe the organization’s procedures for reporting disclosure of ownership and adverse action information to TennCare.

1. **The Plan shall have provisions regarding the reporting of fraud and abuse activities, as required by the contract.**

The MCC’s Plan shall describe the policies and/or procedures for preparing and submitting required reports of fraud and abuse activities as well as identifying the department, person and/or the job title that is responsible for providing said reports.

1. **The Plan shall have provisions regarding conducting a monthly comparison of the MCC’s provider files, including atypical providers and Personal Care Service providers against the Social Security Master Death File, the General Services Administration (GSA) System for Award Management (SAM), and the HHS-OIG LEIE and providing a report of the result of comparison to TennCare OPI each month. The MCC shall establish an electronic database to capture identifiable information on the owners, agents, and managing employees as listed on providers’ disclosure information, as provided by TennCare.**

The MCC’s Plan shall describe the policies and/or procedures for conducting and reporting on monthly searches to ensure that its providers are not included on any of the lists or systems identified in the contract which would cause the provider to be ineligible to render services and receive payment of Medicaid funds. The Plan shall include a monthly report of the result of comparison to TennCare OPI each month.

1. **Have provisions regarding monthly checks for exclusions of their owners, agents, and managing employees. The MCC shall establish an electronic database to capture identifiable information on its owners, agents, and managing employees and perform monthly exclusion checking. The MCC shall provide the State Agency with such database and a monthly report of the exclusion check.**

The MCC’s Plan shall describe the policies and/or procedures for conducting and reporting on monthly searches to ensure that its owners, agents, and managing employees are not included on any exclusion or debarment lists or systems which would cause the individual(s) to be ineligible to participate in administering Medicaid program services and funds.

1. **Have provisions regarding prompt terminations of inactive providers due to inactivity in the past twelve (12) months, unless TennCare provides prior approval for a provider to remain contracted, or as otherwise required by TennCare.**

The MCC’s Plan shall describe the policies and/or procedures for identifying and terminating providers who have not submitted claims for a TennCare member in the previous twelve (12) months. If the MCC provides exceptions for certain provider types or specialties, the exceptions shall be identified in the Plan and accompanied by the organization’s rationale for the exceptions, as well as a statement indicating that the exception has been approved by TennCare.

1. **Have provisions regarding instructions to Personal Care Service providers to maintain written policies and procedures of their business model.**

The policy and procedures to providers shall include at a minimum; roles and responsibilities for key personnel, organizational chart, succession planning, ownership and background checks for all personnel, fraud, waste, and abuse reporting protocols, and employee training as required by the Deficit Reduction Act of 2005 Section 6032.

1. **Outline provisions in place to audit PCS providers to ensure they are maintaining a business model.**

The MCCs shall have provisions in place to perform a coordinated audit of a sampling of PCS providers to ensure PCS providers are only audited by one MCO. Results of the audits shall be submitted (using the template in Appendix O) to TennCare by March 1st each year via the TennCare tracking tool.

1. **The Plan shall outline detailed internal procedures on how information received from the State regarding providers already under investigation or review (PAL providers) is disseminated internally to the appropriate group(s) to ensure those providers are not contacted or investigated.**

The Plan shall describe the steps that are in place to ensure PAL providers are not contacted or investigated unless written approval has been received from the TennCare OPI Director.

1. Provide a staff backup/replacement plan for staff members who are assigned to TennCare’s FWA audits, and investigations. The plan shall include identifying positions related to TennCare’s cases, identifying the critical skills needed, responsibilities and job aids for each position, and providing a plan to cover positions in case of emergency, resignation, or retirement.

1. Provide written, step-by-step procedures of the lifecycle of a tip, an investigation and/or audit. This shall include the detailed procedures for documenting, and reporting information, form letter locations, how to handle various types of tips (data mining, external tips, pre-payment) syntax used for saving files (for instance, all files related to a case must have the case number at the beginning of a filename), etc. The documentation shall be clear and concise why each key action occurred in the event the case needs reassignment.
2. MCCs shall have documented policies and procedures which describe its investigation methods and processes:

* Actions to be taken by the investigator upon initiation of an investigation (i.e., communications, documentation requests, etc.)
* Selection and size of the audit sample(s) including additional audit samples that may be required due to new issues identified during the investigation
* The process for conducting audits or reviews, including identification of all personnel involved in the process, actions taken, and any timeframe(s), as applicable
* Provide policy for how coverage is determined when there are no policies in place by MCC or TennCare.
* The case tracking system used and investigation documentation requirements
* The process for conducting case reviews/staffing
* Preparing cases for referral to TennCare OPI and TBI MFCD
* Administrative actions that may be taken against a provider based on the results of the investigation. This includes actions that may be taken upon receiving a returned referral from TennCare OPI or, actions taken if a referral was not submitted to TennCare OPI due to a lack of sufficient evidence of suspected fraud and abuse; and
* The process for conducting follow-up audits or monitoring activities of providers who have been investigated for suspected fraud or abuse to determine if billing practices have been changed.

## 9.3 Annual Deficit Reduction Act Policies and Procedures

Annually, the MCCs shall be asked to submit to TennCare Internal Audit and Investigations its policies for employees, contractors, and agents that comply with Section 6032 of the Deficit Reduction Act of 2005 which establishes Section 1902(a)(68) of the Social Security Act. The MCCs shall provide the compiled information to OPI upon request.

## 9.4 Annual Recoveries

Each MCC is required to submit an Annual Recoveries report identifying **ALL** administrative and non-administrative recovery activities related to TC lines of business conducted by the MCC including those 365 days or older, and if not specifically defined by OPI during the previous calendar year.

The report shall be submitted via TennCare’s Tracking Tool using the template provided in Appendix H. Examples of Administrative and non-administrative recovery rationale can be found in Appendix A. MCCs should consult with OPI if there is uncertainty regarding recovery rationale.

## 9.5 Summary Results of FWA Performed

The Contractor shall submit reports for both TennCare and CoverKids to TennCare and the State Office of the Inspector General that includes summary results of any fraud and abuse tests performed at the request of the State. The report shall be submitted via TennCare’s tracking tool when requested by OPI.

## 9.6 Monthly Tips Report

Each MCC is required to submit all tips of potential or suspected fraud and abuse received during the previous month, including tips that have not yet been assigned, have been screened out, and/or have been closed with no action, this does not include tips identified solely by algorithms. Additionally, if an MCC initiates a tip as the result from conversation(s) during a meeting, or phone call with a State agency it should be included in the report, and noted the tip came from the applicable agency.

Avoiding redundancy in reporting of Tips is essential. For example,

* If the NPI changes, but all other elements remain the same, list each NPI associated with the allegation
* If the TIN changes, but all other elements remain the same, list each TIN associated with the allegation

All tips shall be reported to TennCare OPI and TBI MFCD by the 5th of each month for tips received for the prior month using the report template provided in Appendix C.

The Tips Report shall be submitted by the MCOs via the SFTP server (unless you have been instructed otherwise) at the following locations:

* /tncare/MCC###/orr/opi/in
* /tncare/MCC###/orr/tbi/in

The PBM Contractor, PPL, and MS shall submit the monthly Tips Report via the SFTP server, and the TC tracking system by the 5th of each month.

## 9.7 Monthly Program Integrity Exception List Report

Each MCC is required to submit a monthly Program Integrity Exception List Report to TennCare OPI that identifies employees, providers, and subcontractors that have been reported on the HHS-OIG LEIE, the GSA SAM, TennCare’s Terminate Provider List, and/or the Monthly Disciplinary Actions issued by the Professional Health Board. The Program Integrity Exception List Report for each month shall be submitted via TennCare’s tracking tool by the 20th day of the following month.

## 9.8 Summary Report for All Programs

Each MCC is required to submit a quarterly Summary Report related to all programs the organization participates in. This information will be used to report out to Federal and State entities and help to alleviate “rush” RFIs as used in the past for reporting. The report template is provided in Appendix M and shall be submitted via TennCare’s Tracking Tool 30 days after the quarter’s end.

## 9.9 PCS Audit Results

The report shall include the results of a sampling audit of PCS providers to ensure they have business models and succession planning in place. The report shall be submitted using the template in Appendix O to TennCare by March 31 via the TennCare tracking tool.

## 9.10 Annual Compliance with 42 C.F.R. Part 455, Subpart B Attestation

The MCCs shall confirm with TennCare on an annual basis that providers are reminded to submit disclosure changes within the guidelines of 42 C.F.R. Part 455, Subpart B using the template provided in Appendix B. The attestation is due each calendar year by March 31, via TennCare’s tracking tool.

## 9.11 Quarterly Fraud and Abuse Activities

Each MCC shall submit a quarterly fraud and abuse activities report. The report shall include all activities related to fraud and abuse during the quarter using the report template provided in Appendix D. The report is due 30 days following the end of each quarter via TennCare’s Tracking Tool.

### 9.11.1 QFA Report Formatting

When naming the Microsoft Excel file, use the following convention:

YYYY **XQTR MCC FWA Activities**

Information shall be reported on a calendar year basis as follows.

* Quarterly: any open and existing information shall roll over to the next quarter and identified as existing.
* Annually: all open and existing information shall roll to the 1st quarter of the new year and be identified as existing, and closed information shall drop off

### 9.11.3 Tab Definitions and Guidelines

#### 9.11.3.a Tab 1 - Summary

The summary tab contains a totality of the information presented in the rest of the QFA report.

**Number of Tips, Audits, and Referrals**

* New – Count of either new Tips, Audits, or Referrals received for the reporting quarter. The MCC tracking number shall be used to obtain the total, accurate number of new tips for the quarter
* Existing – This number will auto populate using the “Open” number at the End of the previous quarter
* Returned (applies to Referrals only) – Count of referrals that were sent to OPI and have been returned to the MCC in the reporting quarter, whether they were referred in a previous quarter or current reporting quarter
* Closed – Count of closed Tips and Audits for the reporting quarter after the MCC has completed any administrative actions
* Open Tips, Audits, or Referrals at the end of the quarter– This is a protected formula which equals: Total of all new and existing tips, Audits, or Referrals, minus the closed for the reporting quarter

**Overpayments** provides information on identified and recovered during the quarter.

**Administrative Actions** provides administrative, disciplinary, and recipient information.

**Provider Enrollment Safeguards** provides enrollment screening information.

To ensure the data in the Summary Tab reflects the information in the supporting tabs, apply the following logic as an accuracy check.

|  |  |
| --- | --- |
| **Logic for Summary Tab** | |
| Number of Tips |  |
| New | 1) Go to the Tips tab 2) Filter column D to dates within the quarter being reported 3) Remove any duplicates from column C |
| Existing | This number will auto populate using the “Open Tips at the End of the Quarter” data from the previous quarter. |
| Closed | 1) Go to the Tips tab  2) Filter column E to dates within the quarter being reported 3) Filter the Status column by “Closed” |
| Open tips at the end of the quarter | Formula: New Tips + Existing Tips – Closed Tips = Existing/Open Tips at the end of the reporting quarter |
| Number of Audits Performed | |
| New | 1) Go to the Audits tab 2) Filter column C to dates within the quarter being reported |
| Existing | This number will auto populate using the “Open Audits at the End of the Quarter” data from the previous quarter |
| Closed | 1) Go to the Audits tab  2) Filter column D to dates within the quarter being reported 3) Filter the Status column by “Closed” |
| Open audits at the end of the quarter | Formula: New Audits + Existing Audits – Closed Audits = Existing/Open Audits at the end of the reporting quarter |
| Number of Referrals Made to MFCD & TennCare | |
| New | 1) Go to the Referrals tab 2) Filter column D to dates within the quarter being  reported 3) Remove any duplicates from column B |
| Existing | This number will auto populate using the “Open Referrals at the End of the Quarter” data from the previous quarter. |
| Returned | 1) Go to the Referrals tab 2) Filter column F to dates within the quarter being reported 3) Remove any duplicates from column B |
| Open referrals at the end of the quarter | Formula: New Referrals + Existing Referrals – Returned Referrals - Closed Referrals = Existing/Open Referrals at the end of the reporting quarter |

#### 9.11.3.b Tab 2 - Tips

The Tips submitted on the QFA should simply be the result of copying and pasting prior Tips from the Monthly submissions and providing an update/status for each Tip.

Tips shall be listed under the current reporting quarter until closed. For example, the Status of the Tip will be changing as a Tip can be listed in Q1 as New, then moved to Existing in Q2 and Closed-Moved to Audit in Q3.

#### 9.11.3.c Tab 3 – Audits Performed

The Audits Performed Tab is meant to capture all audits conducted by the MCC or authorized vendor that were related to program integrity efforts.

All open audits shall be continuously reported in the current reporting quarter if still active with the MCC. For example, if the audit was opened in Q1 and is still under investigation, it shall continuously be reported under Q2, Q3… as existing until closed.

A couple of notes regarding audits:

* The Audits Performed tab may contain audits from numerous departments within the MCC. All audits related to TennCare FWA concerns shall be listed on this tab
* Prospective audit savings shall be listed in column N; but not listed as a recovery amount in column O
* Prospective audit savings shall be listed on tab 5 – Overpayments Identified, but not on tab 6 – Overpayments Recovered
* Audits which are still open, only pending recoupment shall be considered closed for the purpose of this report
* Information regarding cases over 270 days shall be included in the MCC Comment column

#### 9.11.3.d Tab 4 – Referrals Made

The Referrals Made tab is a running snapshot of all referrals sent to OPI and TBI MFCD. The tab shall include all referrals until returned, the process flow for a referral shall begin with the status of ‘New’, then move to ‘Existing’, and ‘Returned’. If a case was referred in a previous quarter, it shall be listed on the current reporting quarter with any status changes until returned.

**Referrals**

* + - If a referral has been closed without any action taken, document the reason for closing in column I
    - If a referral has been closed with action taken, this would be documented on Tab 7 – New PI Actions or Tab 6 – Overpayments Recovered
    - Referrals which are still open, only pending recoupment shall be considered closed for the purpose of this report

#### 9.11.3.e Tab 5 – Overpayments Identified

The Overpayments Identified Tab shall include all identified overpayments related to TennCare services that are likely a result of FWA during the quarter. The MCC shall not report identified overpayments related to administrative errors on this tab. Identified overpayment amounts shall only be the exposure amounts related to the allegation and not total paid amount to the provider/group.

#### 9.11.3.f Tab 6 – Overpayments Recovered

Include overpayments recovered (including overpayments that are over 365 days) that are likely the result of Program Integrity concerns and not administrative errors.

All provider-initiated refunds shall be listed on this tab regardless of overpayment rationale. If the provider is on the Provider Alert List and the refund submitted is equal or greater than the terms as provided by TennCare, then OPI requires notification within ten (10) business days. Please refer to the memo sent to all MCCs outlining this requirement in more detail.

#### 9.11.3.g Tab 7 – New PI Actions

This tab captures relevant administrative actions taken by the MCC on a provider related to Program Integrity efforts such as overpayments collected with formal education, CAPs, etc. The actions listed on this tab shall include all letters to providers related to TennCare claims. These actions could be the result of a retrospective review or prospective review of the provider claims, review of provider billing patterns, etc.

#### 9.11.3.h Tab 8 – Terminations

The Terminations tab shall include all providers and groups that were involuntarily terminated from the MCC network during the reporting quarter. A detailed description of the termination concerns is required.

Voluntary terminations of providers who were under audit by the MCC or the State (e.g., PAL providers) at the time of termination and/or terminated to avoid an audit shall also be reported on this tab. Notification to OPI shall also be made within ten (10) business days regarding these voluntary termination reasons.

**Involuntary Termination Type Reason Codes** (also in template, column R)

| **Termination Types** | **Description** | **Report to HHS-OIG?** | **Reporting Hierarchy if there are multiple termination reasons** |
| --- | --- | --- | --- |
| LI-01 | License validity related | No | 16 |
| LI-02 | Adverse License actions | No | 15 |
| LI-03 | Other (must be explained) | Review | 13 |
| CR-01 | Credentialing - disclosure related concerns | No | 14 |
| CR-02 | Credentialing - not meeting credential requirements | No | 17 |
| CR-03 | Credentialing - not credentialed due to improper billing | Review | 10 |
| CR-04 | Credentialing - not credentialed due to violation of medical guidelines | No | 11 |
| CR-05 | Credentialing - not credentialed due to quality-of-care concerns | Review | 7 |
| CR-06 | Credentialing - not needed in the network due to saturation of provider type or specialty (MCC must provide statistics to justify the saturation) | Review | 8 |
| CR-07 | Credentialing - nonresponsive to credentialing or re-credentialing information requests | Review | 9 |
| CR-08 | Credentialing - other (must be explained) | Review | 12 |
| MT-01 | Provider no longer available to participate | No | 20 |
| MT-02 | Health plan termed the provider due to inactivity | No | 19 |
| MT-03 | Health plan termed the provider due to federal exclusions | No | 18 |
| MT-04 | Health plan termed the provider due to state exclusions | Yes | 3 |
| MT-06 | Health plan termed the provider due to quality-of-care concerns | Review | 4 |
| MT-07 | Health plan termed the provider due to improper billing concerns | Review | 5 |
| MT-08 | Health plan termed the provider due to potential fraud concerns | Yes | 1 |
| MT-09 | Health plan termed the provider due to potential issues related to program integrity | Yes | 2 |
| MT-10 | Health plan termed the provider for other reasons (must be explained) | Review | 21 |

#### 

#### 9.12.3.i Tab 9 – Recipients Referred

The Recipients Referred tab shall include all TennCare recipients that were linked to FWA of the TennCare program during the quarter. These recipients shall be reported to OIG, as necessary, throughout the quarter.

#### 9.11.3.j Tab 10 – Explanation of Benefits (Verification) Information

The report shall include a summary of the number of EOB sampling letters sent by provider group or specialty type during the previous quarter, and information on any complaints received from, or on behalf of, members regarding the accuracy of services billed by the provider.

## 9.12 Intentionally Left Blank

## 9.13 Quarterly Utilization Outlier (Standard Deviation Report)

The DBM shall submit to OPI on a quarterly basis a Utilization Outlier Report listing peer benchmarks and outliers by specialty types and by category of services. The report is submitted by TennCare’s Tracking Tool using a format agreed upon and is due thirty (30) days after the end of each Federal Fiscal Year quarter.

## 9.14 Quarterly Fraud, Waste, and Abuse Cost Savings Information

MCCs shall submit a quarterly cost savings report which includes identified savings, and the methodology used to calculate the cost avoidance. The cost savings information report is separate and apart from recoupments and recoveries and shall include any action(s) taken to reduce the amount of fraud, waste, and abuse in TennCare’s LOBs. The report is due 30 days after the quarter ends and a template has been provided in Appendix P. The report shall be submitted via TennCare’s Tracking Tool.

MCC’s shall include all savings initiatives currently in practice, and the methodology used to calculate the cost avoidance or note that the calculation is proprietary. Examples of areas of cost savings to include are:

* Pre-payment edits
* CLIA edits
* Prospective reviews
* Medical records review
* Claims audit pre-pay
* Provider education
* Outlier provider notification letters and behavior modifications from data analytics
* Provider outliers who are flagged for specific outcome measures from cost analysis
* TennCare reimbursement workgroups
* Policy creation derived from OPI’s Policy Focus Workgroup
* Cost avoidance from proprietary methodologies
* Any other cost savings measure(s) in place

The extrapolation of savings is determined from when a behavior was noted until the end of the calendar year. For example, if a doctor started charging a higher rate than allowable in March and after education the behavior changed, the savings incurred would be from March-December.

## 9.15 Provider-Initiated Refunds Report

MCCs shall submit a monthly provider-initiated overpayment report which includes all provider-initiated refunds totaling five-hundred dollars ($500.00) or more, either individually or cumulatively in a 30-day period by the 15th of each month via TOPS. If no provider refunds were received during the reporting time, submit the report stating no provider-initiated refunds received.

## 9.16 Ad Hoc Reports

All Requests for Information (RFI) or On Request Reports (ORR) responses shall include all applicable information from all MCO: units, sub-contractors, vendors, and any other entity associated with TennCare claims. In response to an RFI or ORR, all information shall be complete and accurate. RFIs and ORRs will be sent to the MCCs via TennCare’s tracking tool and due dates are outlined in the Office of Program Integrity Request for Information/On Request Report form (RFI/ORR form). An example of the form is included in Appendix I.

### 9.16.1 Requests for Information

TennCare OPI may send a Request for Information (RFI) to an MCC for data or documentation related to an investigation or other program integrity-related activity. The *RFI/ORR* form (see Appendix I) contains the following information:

* Request Urgency
* Request Type (i.e., RFI or ORR)
* Requester Name, Phone Number, and E-mail Address
* Date of Request
* Response Due Date
* MCC Recipient(s)
* Information Requested
* Additional Comments from OPI (as applicable)

The MCC shall submit all requested information to TennCare OPI by the response due date. If circumstances prohibit the MCC from submitting some or all the requested information by the response due date, the MCC must contact the designated TennCare OPI investigator prior to the response due date to discuss the issue(s) and determine either a new due date for the unavailable information or other action steps, as appropriate. The MCC will still be responsible for submitting all other requested information to TennCare OPI by the response due date.

When submitting the requested information, the MCC shall complete the following required information on the RFI/ORR form:

* Whether the requested information is included in the submission.
* MCC comments or explanations regarding the submitted information. If the MCC is not submitting information requested by the TennCare OPI investigator, this field shall provide a brief explanation of the reason the information is not complete and identify any new submission date(s) agreed upon in discussion with the investigator.
* Name, phone number, and email address of the MCC respondent.
* Additional comments from the MCC, as applicable.

If the MCC does not submit all requested information by the response due date, and has not previously discussed alternative due dates or actions with the TennCare OPI investigator, the following actions may be taken:

* The TennCare OPI investigator may reach out to the MCC to inquire about the missing information
* If the MCC submits some, but not all, of the requested information, then TennCare OPI may deny the submitted RFI response
* The TennCare OPI investigator may send the MCC an On-Request Report (ORR)

### 9.16.2 On-Request Reports

If a TennCare OPI investigator is unable to obtain required information through a direct request (i.e., phone or email) or an RFI, the MCC may be issued an On-Request Report (ORR). As required by the CRA, the MCC must respond to the ORR and submit requested information within three (3) business days, unless otherwise specified by TennCare OPI. The MCC shall be subject to liquidated damages as specified in the CRA for reports determined to be late, incorrect, incomplete, deficient, or not submitted in the manner and format prescribed by TennCare OPI.

## 9.17 MCC Audit Exposure Form

The Audit Exposure Form (Appendix Q) (or a form approved by OPI that provides the same information) shall be used for all providers expected to be discussed during the monthly calls as outlined in Section 8.1.c. These forms are a tool that is two-pronged; they provide the needed information to OPI to make the best decision based on the information given, and they provide a means of tracking pending referrals. These forms shall be completed with high level detail so the case can be discussed on the phone with OPI and the MCC. These forms shall be attached to the meeting invite and submitted to TennCare ***at a minimum of two (2) days*** prior to the monthly meeting.

## 9.18 Denied Provider Credentialing Summary

Quarterly MCCs shall submit initial credentialing applications that have been denied, and the summary form outlined in Appendix E.  The credentialing applications shall be embedded within the Excel report template (Column L) when submitted. This report shall be submitted via TennCare’s tracking tool by the 30th day after the end of the reporting period.

## 9.19 Notification of Exceeding 270 Days

Each MCC is required to notify OPI if any case will exceed 270 days using the Excel template provided in Appendix R. A case may be removed from the report once administrative action has been taken and listed on the report as closed once. The information should be cumulative with the current case status and submitted by the 20th of each month via email to the Compliance Manager.

## 9.20 Non-Registered Provider Payment Report

Each MCC is required to submit a quarterly report identifying payments made to providers without a Medicaid ID as outlined in Appendix N. The Report shall be submitted via TennCare’s tracking tool no later than 30 calendar days following the end of each quarter.

# **Section 10: DIDD Information**

## 10.1 Tips Report

DIDD shall submit all tips, and any related attachments of potential or suspected fraud and abuse received during the previous month to OPI. No action (audit, investigation, contacting provider, etc.) shall be performed on any of the tips prior to sending to OPI.

All tips shall be reported to TennCare OPI using the process outlined in Section 9.6.

## 10.2 Quarterly Report Information

The DIDD Quality Assurance and Fiscal Accountability Review (FAR) Units within the Office of Quality Management will continue to prepare the QFA report and send it to Risk Management; Risk Management will combine the regional QA and FAR information and submit it to OPI as outlined in Section 9.12.

OPI will continue to hold Quarterly fraud, waste, and abuse meetings with DIDD and DIDD will continue to participate in other FWA meetings as mutually agreed upon by DIDD and OPI.

Any MCC that receives tips from OPI regarding DIDD services shall include these on their QFA report and follow the same process as any other tip as outlined in Section 9.12.

When a tip is received from TennCare OPI use “TC OPI- DIDD” as the source, this will allow OPI to easily identify all DIDD tips that have been sent to MCCs.

DIDD information shall be combined with current reports but need to be identifiable that they are DIDD tips.

## 10.3 Quality Assurance (QA)

Quality Assurance reports will be submitted to OPI upon request.

## 10.4 Fiscal Accountability Review

Financial accountability reviews will be submitted to OPI upon request.

## 10.5 Risk Management

Risk Management will continue to receive potential FWA cases from QA and FAR and prepare the referral to submit to OPI using the referral process outlined in Section 9.1. If the information is not sufficient to complete a referral as outlined in Section 9.1 then submit the information on the monthly Tip report or contact OPI for further guidance.

Risk Management shall copy the OPI Director and Compliance Manager on final audit reports.

## 10.6 DIDD Deliverables

Section 9, Table 1 of the MCPIM provides a complete list of deliverables that are due to TC OPI from DIDD, the due date, and the method they should be submitted.

# **Section 11: Fiscal Employer Agent**

This section will outline the requirements and expectations of OPI in relation to the Fiscal Employer Agent (FEA) contracts in identifying, reporting, addressing, and preventing fraud, waste, and abuse in the Medicaid program. Section 9 of this manual provides a complete list all deliverables due to OPI from the MCCs, and CDTN. Below are detailed requirements that are needed in addition to requirements outlined in the contract. If some sections point to another section in the manual, please provide the information for both sections.

## 11.1 Training

Annual training for the contractor’s Staff, including Supports Brokers, whether employed or contracted, Participant/Representative, EOR, or the Workers shall be developed as outlined in the contract, and provided to TC OPI. The training shall include at a minimum, the rules and regulations of providing services, information on FWA such as the definitions, and scenarios of FWA, appropriate and non-appropriate billing practices, the possible consequences if rules and regulations are not followed, and any other requirements outlined in the contract. In addition, to the training requirements listed in the Compliance Plan, annual training shall be provided on the following topics, with quarterly reminders.

* Providing care as outlined in the Plan of Care (POC)
* Providing care at the member’s home unless the POC details otherwise
* Self-reporting inpatient or hospital stays
* Documentation needed for billing for a 2nd person for Level 4 services
* Overlapping services (submitting a bill to two or more MCOs for the same services provided to a member, or providing service at the same time for two people when it is not detailed in the POC)

A trackable training method for annual and quarterly reminders shall be used and should include the printed name and title of attendees, date of training. And, at the end of training the signature of attendees is required, attesting they understand the topics covered, including consequences if regulations are not followed.

## 11.2 Deliverables

### 11.2.1 Monthly Tips Report

All tips of confirmed or suspected fraud, waste, and abuse, by the Contractor's Staff, including Supports Brokers, whether employed or contracted, Participant/Representative, EOR, or the Workers, shall be reported to OPI as outlined in Section 9.6 of this manual.

### 11.2.2 Annual Compliance Plan

A Fraud, Waste, and Abuse Compliance Plan (Plan) and Crosswalk (Appendix J) shall be submitted to TC OPI annually. A paper and electronic copy of the Plan shall be provided to TennCare OPI within ninety (90) calendar days of the MCC’s contract execution date, and annually thereafter via TennCare’s tracking tool.

The Contractor shall develop and implement a fraud, waste, and abuse compliance plan for ensuring protections against actual or potential fraud, waste, and abuse. The detailed fraud, waste, and abuse compliance plan shall define how the Contractor will adequately identify and report suspected fraud, waste, and abuse by Participants/Representatives, Workers, EOR, and employees as outlined in Section 9.2 of this manual, and in the contract elements listed below.

1. Written Policies and Procedures. The Contractor shall develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards for the identification and reporting of incidents of potential fraud, waste, and abuse by Participants/Representatives, Workers, EOR, and the Contractor and its employees. Including policies and procedures that ensure Workers are eligible to provide services and Participants are eligible to receive them on a regular basis.
2. Training and Education. The Contractor shall establish effective program integrity, and fraud, waste, and abuse (FWA) training and education for Participants/Representatives, Workers, EOR, and employees. The FWA training shall include what FWA is, scenarios of fraud, including EVV fraud, not self-reporting when a member is in the hospital or unavailable for services, information on the State agencies that monitor fraud, and how to report it. Additionally, the program integrity training shall be tailored to each audience and shall be provided when first hired, and/or before the start of services. Training shall be administered annually thereafter.
   1. The training for employees shall include at a minimum:
      1. The rules and regulations surrounding a Worker
      2. Fraud, waste, and abuse training
      3. False Claims Act (31 U.S.C. §§ 3729-3733)
      4. Section 1902(a)(68) of the Act
   2. The training for Participants shall include at a minimum:
      1. The rules and regulations surrounding a Worker
      2. Notification of changes in relationship to Participant
      3. Fraud, waste, and abuse training
      4. False Claims Act (31 U.S.C. §§ 3729-3733
   3. The training for Workers, EOR shall include at a minimum:
      1. The rules and regulations surrounding a Worker
      2. Self-reporting if Participant is in the hospital or unavailable for services
      3. Notification of changes in relationship to Participant, or address
      4. Cloning of Participant records
      5. Fraud, waste, and abuse training
      6. False Claims Act (31 U.S.C. §§ 3729-3733
3. Effective Lines of Communication. The Contractor shall establish effective lines of communication with its Participants/Representatives, Workers, and employees to ensure compliance with program integrity standards.
4. Well-Publicized Disciplinary Guidelines. The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.
5. Process for Reporting Potential or Actual Fraud, Waste, and Abuse. The Contractor shall provide information and a procedure for Participants/Representatives, Workers, EOR, and employees to report incidents of potential or actual fraud, waste, and abuse to the Contractor and to TennCare OPI, in a manner and format required by TennCare.
6. Development of Corrective Action Initiatives. The Contractor's fraud, waste, and abuse compliance plan shall include provisions for corrective action initiatives.
7. Cooperation with Fraud, Waste, and Abuse Investigations. The Contractor's fraud, waste, and abuse compliance plan shall include provisions for cooperating with all fraud, waste, and abuse investigation efforts by the MCOs, TennCare, TBI MFCD, AG/MFID and/or other state and federal offices. These provisions shall include specific documentation which shall be made available to TennCare, MCOs, and/or state and federal offices, upon request, at no cost to the requesting agency, and in accordance with applicable TennCare guidance and MCO//FEA partnership agreements.
8. Include Written policies regarding the False Claims Act (FCA) including whistleblower protections under the FCA and/or Tennessee Medicaid False Claims Act.

# Appendices

To use the templates included in the appendices, click on the icon twice and use the “Save As” feature in the file to save a master copy to your hard drive or server.

Appendix A: Non-Administrative and Administrative Rationale

Appendix B: Annual 42 C.F.R. Part 455, Subpart B Attestation

Appendix C: Tips Report

Appendix D: Quarterly Fraud and Abuse Activities Report

Appendix E: Quarterly Denied Provider Credentialing Summary

Appendix F: MCC Referral Form

Appendix G: MCC Referral Checklist

Appendix H: Annual Recoveries Report

Appendix I: Request for Information or On Request Reports

Appendix J: Annual FWA Compliance Plan Crosswalk

Appendix K: Fraud and Abuse DRA Crosswalk

Appendix L: Monthly Program Integrity Exception List

Appendix M: Summary Report-All Programs

Appendix N: Quarterly Non-Registered Provider Payment

Appendix O: Annual PCS Business Model Audit Results

Appendix P: Quarterly Cost Savings Report

Appendix Q: Audit Exposure Form

Appendix R: Notification of Investigation Exceeding 270 Days

Appendix S: Provider Initiated Refunds

Appendix T: Monthly Call Agenda

Appendix U: Program Integrity Policies

## Appendix A: Non-Administrative and Administrative Rationale



## Appendix B: 42 C.F.R. Part 455, Subpart B Attestation



## Appendix C: Tips Report



## Appendix D: Fraud and Abuse Activities Report



## Appendix E: Denied Provider Credentialing Summary



## Appendix F: MCC Referral Form



## Appendix G: MCC Referral Checklist



## Appendix H: Recoveries Report



## Appendix I: Request for Information or On Request Report



## Appendix J: FWA Compliance Plan Crosswalk



## Appendix K: Fraud and Abuse DRA Crosswalk



## Appendix L: Program Integrity Exception List



## Appendix M: Summary Report All Programs



## Appendix N: Non-Registered Provider Payment



## Appendix O: PCS Business Audit Results



## Appendix P: Cost Savings Report



## Appendix Q: Audit Exposure Form



## Appendix R: Notification of Exceeding 270 Days



## Appendix S: Provider Initiated Refunds



## Appendix T: Monthly Call Agenda



## Appendix U: TennCare Program Integrity Policies

TennCare Program Integrity policies are listed below and may be viewed by clicking on the hyperlink. The syntax used for each policy contains the policy business owner, the year the policy was introduced, and the number of revisions; For example, PI 11-002 is owned by Program Integrity, introduced in 2011 and has been revised two times.

[PI 11-002](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi11-002.pdf) Contractor and Provider Screening of Employees and Contractors

[PI 12-001](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi12001.pdf) Credible Allegation of Fraud

[PI 10-001](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi10-001.pdf) Disclosure of Ownership or Control; Changes in Ownership; and Program Integrity Reporting Responsibilities

[PI 08-001](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi08001.pdf) False Claims Act Policy

[PI 11-003](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi11003.pdf) Federal Provider Terminations and Exclusions

[PI 11-001](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi11001.pdf) Overpayments and Section 6402 of the Affordable Care Act

[PI 11-004](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi11004.pdf) Prohibitions of Payments to Institutions or Entities Outside of the USA

[PI 11-005](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi11005.pdf) Provider Assignment or Reassignment of Payments

[PI 13-001](https://www.tn.gov/content/dam/tn/tenncare/documents2/pi13001.pdf) Provider Terminations for Inactivity