TennCare Policy Manual

Policy No: PI 12-001 (Rev. 1)	
Subject: Credible Allegation of Fraud	
Approval: D-i-d Searcy	**Date:** 12-17-2015

PURPOSE:

Changes made by the Affordable Care Act require states to suspend payments to providers in cases where there exists a pending investigation of a credible allegation of fraud. Where there is good cause shown to not suspend payments, the State may choose not to suspend payment, or alternatively may impose a partial suspension.[1] The purpose of this policy is to describe the process by which the Bureau of TennCare determines that there is a credible allegation of fraud and to explain the options available to providers.

POLICY:

It is the policy of the Bureau of TennCare to comply with federal law and to suspend payments to providers when an investigation is underway that involves a credible allegation of fraud. An exception may be made if there is good cause not to suspend payments to a particular provider or to suspend only a portion of the payments.

BACKGROUND INFORMATION:

There are numerous sources of information that may form the basis of a **credible allegation of fraud.** These sources include, but are not limited to:

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

Allegations are considered to be credible when they have **indicia of reliability** and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

[1] 42 CFR § 455.23(a)(1)

Indicia of reliability are factors which TennCare examines in determining whether a credible allegation of fraud exists. These factors include, but are not limited to:

- Firsthand knowledge,
- Corroborating witness,
- Witness conflict (disgruntled employee),
- Prior bad acts,
- Pattern of bad acts,
- Documentary proof,
- Admission by provider,
- Expert opinion, and
- Indictment by a court of competent jurisdiction.[2]

PROCEDURES:

1. The Provider Review Committee (PRC) at TennCare, which includes representatives from a number of TennCare offices, makes recommendations about potential credible allegations of fraud, using one or several of the indicia of reliability identified above and considering facts on a case-by-case basis. All cases of suspected provider fraud are referred to the Medicaid Fraud Control Unit (MFCU) in accordance with 42 CFR § 455.23(d)(1).

   Referrals to the MCFU are made in writing by the next business day (or earlier) after a suspension of payment is enacted.[3] The referral notice contains all the information listed in the "minimum criteria" of the CMS-MIG Performance Standard as required by 42 CFR § 455.23(d)(2)(ii).

2. TennCare shall determine whether there is good cause not to suspend payment or to suspend payment only in part.

   a. Reasons that may constitute "good cause" not to suspend payment are listed at 42 CFR § 455.23(e) and Rule 1200-13-18-.02(19).
   b. Reasons that may constitute "good cause" to suspend payment only in part are listed at 42 CFR § 455.23(f) and Rule 1200-13-18-.02(20).

3. The State will issue written notice to providers of a suspension of payment. See Rule 1200-13-18-.05(2). It should be noted that the rule allows for notice to be provided within certain timeframes *after* the suspension has occurred:

   - Five (5) days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
   - Thirty (30) days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed ninety (90) days. [4]

[2] TennCare Rule 1200-13-18-.02
[3] 42 CFR § 455.23(d)(2)
[4] 42 CFR § 455.23(a)(3)(b)

The contents of the notice, including notification of provider appeal rights, are described at 42 CFR § 455.23(b) and Rule 1200-13-18-.05(3) and (6)

3. If TennCare's referral is accepted by the MFCU, TennCare will continue to suspend provider payment.[5] The Tennessee Bureau of Investigation (TBI) is required to provide a quarterly update to the State certifying that the matter continues to be under investigation.[6] The suspension can be a full suspension for all claims submitted by the provider or a partial suspension for only certain services. If the TBI declines the referral the State will discontinue the suspension unless it has separate State authority to suspend.[7]

4. Provider appeals of suspensions are conducted in accordance with 42 CFR § 455.23(a)(3) and Rule 1200-13-18-.01.

5. Suspensions of payment are temporary and shall end when either of the conditions identified in 42 CFR § 455.23(c) and Rule 1200-13-18-.05(5) are met.

6. The State will retain records regarding any suspensions, the decision not to suspend or the decision to suspend only in part for a period of 5 years.[8]

7. The State shall annually report to the Secretary a summary of its suspension activities for the year.[9]

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Program Integrity
Office of General Counsel

REFERENCES:

42 CFR §§ 455.21 and .23
http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div6&view=text&node=42:4.0.1.1.13.1&idno=42#42:4.0.1.1.13.1.136.10

Tennessee Rule 1200-13-18
http://share.tn.gov/sos/rules/1200/1200-13/1200-13.htm

[5] 42 CFR § 455.23(d)(3)
[6] 42 CFR § 455.23(d)(3)(ii)
[7] 42 CFR § 455.23(d)(4)
[8] 42 CFR § 455.23(g)
[9] 42 CFR § 455.23(g)(3)

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