

**MINIMUM FRAUD AND ABUSE PREVENTION, DETECTION,  
AND REPORTING REQUIREMENTS FOR RITE CARE AND  
RHODY HEALTH PARTNERS MEMBERS**

**Center for Child and Family Health  
Department of Human Services  
State of Rhode Island  
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Cranston, RI 02920**

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**MINIMUM FRAUD AND ABUSE PREVENTION, DETECTION,  
AND REPORTING REQUIREMENTS FOR RITE CARE AND  
RHODY HEALTH PARTNERS MEMBERS**

*“Americans should never accept crime or corruption as a way of life. There is a system in place in our Republic to address a citizen’s problems and to work out a just conclusion. This structure includes the vast a majority of honest, hard-working individuals with whom we are privileged to work including governmental agencies, elected officials, responsible private sector mediators and, of course, prosecutors, Attorney General, U.S. Attorney and the courts.”<sup>1</sup>*

Fraud and abuse in State Medicaid programs has been a growing concern. The General Accounting Office (GAO) recently found<sup>2</sup>:

“Various forms of Medicaid fraud and abuse have resulted in substantial financial losses to states and the federal government. Fraudulent and abusive billing practices committed by providers including billing for services, drugs, equipment or supplies not provided or not needed. Providers have also been found to bill for more expensive procedures than were actually provided.”

In response to fraud and abuse concerns, Congress enacted Section 6034 of the Deficit Reduction Act of 2005 (DRA). Section 6034, which creates Section 1936 of the Social Security Act (SSA), establishes in law for the first time the *Medicaid Integrity Program*. The Rhode Island Medicaid Program must comply with the provisions of Section 1936 and related provisions of the DRA that apply directly to States and entities that contract with State Medicaid programs, including:

- Any entity which receives or makes annual Medicaid payments of at least \$5 million must provide Federal False Claims Act education to their employees.
- Medicaid payment is prohibited for the ingredient cost of a drug for which the pharmacy has already received payment under Medicaid (other than a reasonable restocking fee).
- Beginning July 1, 2006, individuals who declare themselves to be U.S citizens or nationals will be required to provide satisfactory documentary evidence of citizenship or national status.
- Any provider of emergency services that does not have a contract in effect with a Medicaid-participating managed care organization (MCO) must accept as

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<sup>1</sup> Rockoff, A.A. *SCI 37<sup>th</sup> Annual Report*, State of New Jersey Commission of Investigation, 2005.

<sup>2</sup> United States General Accounting Office. *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GA-04-707, June 2004, 2.

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payment in full no more than the amount (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it would collect under Medicaid fee-for-service (FFS).

The State of Rhode Island has been similarly concerned about fraud and abuse. Chapter 40-8.2 of the General Laws of Rhode Island addresses Medical Assistance Fraud and defines “prohibited acts” and various courses of action that may be pursued by the State in instances of such acts, including civil actions, criminal actions, barring program participation, and suspension of payment. There is a 10-year statute of limitations provided for in Chapter 40-8.2

This document delineates the minimum requirements that a Medicaid-participating Health Plan must have for its Fraud and Abuse Function in its *Contract for Managed Care Services* (Agreement) with the Rhode Island Department of Human Services (Department) to provide or arrange for services for RIte Care and Rhody Health Partners Members in order to comply with Federal and State requirements.

### **1. Definitions**

The following terms shall have the meaning specified in 42 CFR 455.2 as follows:

- *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- *Conviction* or *Convicted* mean that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
- *Exclusion* or *Excluded* mean that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
- *Fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- *Furnished* refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

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- *Practitioner* means a physician or other individual licensed under State law to practice his or her profession.
- *Suspension* or *Suspended* means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

The “prohibited acts” defined in Section 40-8.2-2 of the General Laws of Rhode Island are attached to this document as Attachment A.

### **2. Minimum Requirements for Written Policies and Procedures**

As required by Section 3.07.03 of the Agreement, the Contractor agrees to have written policies and procedures for the prevention, detection, and reporting of suspected Fraud and Abuse. At a minimum, such policies and procedures shall include:

- Provisions for the review of all practitioners and other providers within its network using criteria for credentialing which includes a determination that the provider is not currently excluded from participation in Medicare or Medicaid or is otherwise not suspended from practice under Rhode Island law or regulation.
- Provisions to monitor payments for claims or services that include but are not limited to review for:
  - Billing for services not furnished
  - Billing for services not medically necessary
  - Duplicate billing
  - Billing for services that do not meet professionally recognized standards for care
  - Billing for “phantom” providers
  - “Upcoding” or inappropriate billing that results in a loss to the Medicaid managed care program
  - “Unbundling”
  - Inappropriate or lack of documentation to support items or services billed
  - Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
  - Soliciting or receiving kickbacks
  - Violating Medicaid managed care policies, procedures, rules, regulations, and/or statutes
- Provisions pertaining to Members that include but are not limited to:
  - Excessive use or overuse of RIte Care or Rhody Health Partners/Medicaid benefits

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- Using another's RItE Care or Rhody Health Partners/Medicaid identification (ID) card
  - Lending, altering, or duplicating a RItE Care or Rhody Health Partners /Medicaid ID card
  - Altering or forging prescriptions
  - Providing incorrect eligibility or false information to a practitioner or other provider to obtain items or services
  - Simultaneously receiving benefits in Rhode Island and another State
  - Knowingly assisting practitioners and other providers in furnishing services to defraud the RItE Care or Rhody Health Partners/Medicaid program
- A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, and to recover overpayments or otherwise sanction practitioners and other providers. Such description shall include criteria for referral of suspected Fraud and Abuse to the Rhode Island Department of Human Services and the Rhode Island Department of the Attorney General and criteria for when other actions may be taken (e.g., provider education and suspension).
  - A description of specific controls in place for Fraud and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post processing review of claims, and record reviews. The controls should include prepayment, post-payment, and retrospective reviews as well as "data mining".

A Medicaid-participating Health Plan's policies and procedures shall be submitted to the Department for review and approval.

### **3. Education Plan**

A Medicaid-participating Health Plan shall develop a plan for educating a Medicaid-participating Health Plan's employees, agents, and representatives relating to Fraud and Abuse. Such plan shall include detailed information about the False Claims Act, any State laws pertaining to civil and criminal penalties for false claims and statements, whistleblower protections, and a Medicaid-participating Health Plan's policies and procedures for preventing, detecting, and reporting Fraud and Abuse. In addition, a Medicaid-participating Health Plan's plan shall describe the process for ensuring that a Medicaid-participating Health Plan's employees, agents, and representatives are appropriately educated on Fraud and Abuse.

A Medicaid-participating Health Plan shall develop a plan for educating practitioners and other providers relating to Fraud and Abuse. Such plan shall include detailed information about the False Claims Act, any State laws pertaining to civil and criminal penalties for false claims and statements, whistleblower protections, a Medicaid-participating Health

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Plan's policies and procedures for preventing, detecting, and reporting Fraud and Abuse, and how to file a suspected Fraud or abuse complaint.

A Medicaid-participating Health Plan shall develop a plan for educating Members relating to Fraud and Abuse. Such plan shall include detailed information about the False Claims Act, any State laws pertaining to civil and criminal penalties for false claims and statements, whistleblower protections, and a Medicaid-participating Health Plan's policies and procedures for preventing, detecting, reporting Fraud and Abuse, and how to file a suspected Fraud or abuse complaint. Member materials pertaining to Fraud and Abuse must be written at no higher than a sixth-grade level and must be submitted to the Department for approval.

### **4. Fraud and Abuse Reporting Requirements**

The following sections describe the Fraud and Abuse reporting requirements.

#### **4.1 Forwarding Individual Cases**

A Medicaid-participating Health Plan shall forward a case of suspected fraud or abuse to the Department and the Department of the Attorney General for further action within five (5) business days of a Medicaid-participating Health Plan's conclusion of the initial investigation of the case.

#### **4.2 Notification of Intent to Recover Funds Case**

Written notification must be sent by a Medicaid-participating Health Plan to the Department within five (5) business days of a Medicaid-participating Health Plan's intent to recover funds pursuant to fraud and abuse investigations outcomes, and approval must be obtained by a Medicaid-participating Health Plan from the Department prior to collection of those funds.

#### **4.3 Quarterly Reports**

A Medicaid-participating Health Plan shall submit a quarterly report summarizing its Fraud and Abuse activities for the quarter to the Department and the Department of the Attorney General. This report is due no later than thirty (30) days after the end of the reporting quarter. The required format for such reports will be provided at the execution of the Agreement.

#### **4.4 Where Notifications and Reports Are To Be Sent**

Reports and written notifications shall be sent by secure electronic mail to:

Rhode Island Department of Human Services

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Deborah Barclay, Esq.  
Dbarclay@dhs.ri.gov  
600 New London Avenue  
Louis Pasteur Building #57  
Cranston, RI 02920

Rhode Island Department of Attorney General  
James Dube, Esq.  
Jdube@riag.ri.gov  
Medicaid Fraud Control Unit  
150 South Main Street  
Providence, RI 02903

Case notifications may also be filed on-line at:  
<https://www.dhs.ri.gov/dynamic/fraudAbuseIntro.jsp>

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**ATTACHMENT A**

**SECTION 40-8.2-2 OF THE GENERAL LAWS OF RHODE ISLAND**

*Revised 03/24/2010*



**ATTACHMENT A**

**SECTION 40-8.2-2 OF THE GENERAL LAWS OF RHODE ISLAND**

**§ 40-8.2-3 Prohibited acts.** – (a) It shall be unlawful for any person intentionally to:

(1) Present or cause to be presented for preauthorization or payment to the Rhode Island Medicaid program:

(i) Any materially false or fraudulent claim or cost report for the furnishing of services or merchandise; or

(ii) Present or cause to be presented for preauthorization or payment, any claim or cost report for medically unnecessary services or merchandise; or

(iii) To submit or cause to be submitted materially false or fraudulent information, for the intentional purpose(s) of obtaining greater compensation than that to which the provider is legally entitled for the furnishing of services or merchandise; or

(iv) Submit or cause to be submitted materially false information for the purpose of obtaining authorization for furnishing services or merchandise; or

(v) Submit or cause to be submitted any claim or cost report or other document which fails to make full disclosure of material information.

(2) Solicit, receive, offer, or pay any remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, to induce referrals from or to any person in return for furnishing of services or merchandise or in return for referring an individual to a person for the furnishing of any services or merchandise for which payment may be made, in whole or in part, under the Rhode Island Medicaid program.

(ii) Provided, however, that in any prosecution under this subsection, it shall not be necessary for the state to prove that the remuneration returned was taken from any particular expenditure made by a person.

(3) Submit or cause to be submitted a duplicate claim for services, supplies, or merchandise to the Rhode Island Medicaid program for which the provider has already received or claimed reimbursement from any source, unless the duplicate claim is filed

(i) For payment of more than one type of service or merchandise furnished or rendered to a recipient for which the use of more than one type of claim is necessary; or

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(ii) Because of a lack of a response from or a request by the Rhode Island Medicaid program, provided, however, in such instance a duplicate claim will clearly be identified as such, in writing, by the provider; or

(iii) Simultaneous with a claims submission to another source of payment when the provider has knowledge that the other payor will not pay the claim.

(4) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for service or merchandise which was not rendered to a recipient.

(5) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for services or merchandise which includes costs or charges not related to the provision or rendering of services or merchandise to the recipient.

(6) Submit or cause to be submitted a claim or refer a recipient to a person for services or merchandise under the Rhode Island Medicaid program which are intentionally not documented in the provider's record and/or are medically unnecessary as that term is defined by § 40-8.2-2(7).

(7) Submit or cause to be submitted to the Rhode Island Medicaid program a claim which materially misrepresents:

(i) The description of services or merchandise rendered or provided to a recipient;

(ii) The cost of the services or merchandise rendered or provided to a recipient;

(iii) The dates that the services or merchandise were rendered or provided to a recipient;

(iv) The identity of the recipient(s) of the services or merchandise; or

(v) The identity of the attending, prescribing, or referring practitioner or the identity of the actual provider.

(8) Submit a claim for reimbursement to the Rhode Island Medicaid program for service(s) or merchandise at a fee or charge which exceeds the provider's lowest fee or charge for the provision of the service or merchandise to the general public.

(9) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for a service or merchandise which was not rendered by the provider, unless the claim is submitted on behalf of:

(i) A bona fide provider employee of such provider; or

(ii) An affiliated provider entity owned or controlled by the provider; or

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(iii) Is submitted on behalf of a provider by a third party billing service under a written agreement with the provider, and the claims are submitted in a manner which does not otherwise violate the provisions of this chapter.

(10) Render or provide services or merchandise under the Rhode Island Medicaid program unless otherwise authorized by the regulations of the Rhode Island Medicaid program without a provider's written order and the recipient's consent, or submit or cause to be submitted a claim for services or merchandise, except in emergency situations or when the recipient is a minor or is incompetent to give consent. The type of consent to be required hereunder can include verbal acquiescence of the recipient and need not require a signed consent form or the recipient's signature, except where otherwise required by the regulations of the Rhode Island Medicaid program.

(11) Charge any recipient or person acting on behalf of a recipient, money or other consideration in addition to, or in excess of the rates of remuneration established under the Rhode Island Medicaid program.

(12) Enter into an agreement, combination or conspiracy with any party other than the Rhode Island Medicaid program to obtain or aid another to obtain reimbursement or payments from the Rhode Island Medicaid program to which the person, recipient, or provider seeking reimbursement or payment is not entitled.

(13) Make a material false statement in the application for enrollment as a provider under the Rhode Island Medicaid program.

(14) Refuse to provide representatives of the Medicaid fraud control unit upon reasonable request, access to information and data pertaining to services or merchandise rendered to eligible recipients, and/or former recipients while recipients under the Rhode Island Medicaid program.

(15) Obtain any monies by false pretenses through the use of any artifice, scheme, or design prohibited by this section.

(16) Seek or obtain employment with or as a provider after having actual or constructive knowledge of a then existing exclusion issued under the authority of 42 U.S.C. § 1320a-7.

(17) Grant or offer to grant employment in violation of a then existing exclusion issued under the authority of 42 U.S.C. § 1320a-7, having actual or constructive knowledge of the existence of such exclusion.

(18) File a false document to gain employment in a Medicaid funded facility or with a provider.

(b) A provider or person who violates any provision of subsection (a), excepting subsection (a)(14), (a)(16), or (a)(18), is guilty of a felony for each violation, and upon

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conviction therefore, shall be sentenced to a term of imprisonment not exceeding ten (10) years, nor fined more than ten thousand dollars (\$10,000), or both.

(2) A provider or person who violates the provisions of subsection (a)(14), (a)(16), or (a)(18), shall be guilty of a misdemeanor for each violation and, upon conviction, be fined not more than five hundred dollars (\$500).

(3) Any provider who knowingly and willfully participates in any offense either as a principal or as an accessory, or conspirator shall be subject to the same penalty as if the provider had committed the substantive offense.

(c) The provisions of subsection (a)(2) shall not apply to:

(1) A discount or other reduction in price obtained by a person or provider of services or merchandise under the Rhode Island Medicaid program, if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the person or provider under the Rhode Island Medicaid program.

(2) Any amount paid by an employer to an employee, whom has a bona fide employment relationship with the employer, for employment in the provision of covered services or merchandise furnished under the Rhode Island Medicaid program.

(3) Any amounts paid by a vendor of services or merchandise to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services or merchandise which are reimbursed by the Rhode Island Medicaid program, as long as:

(i) The purchasing agent has a written agreement with each individual or entity in the group that specifies the amount the agent will be paid by each vendor (where the sum may be a fixed sum or a fixed percentage of the value of the purchases made from the vendor by the group under the contract between the vendor and the purchasing agent); and

(ii) In the case of an entity that is a provider of services to the Rhode Island Medicaid program, the agent discloses in writing to the individual or entity in accordance with regulations to be promulgated by the department, and to the department upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

**ATTACHMENT B**  
**FRAUD AND ABUSE QUARTERLY REPORT FORMAT**

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reportfraudFINAL.xls