Rule No. 560-X-4-.04. Fraud, Waste, and/or Abuse by Providers.

(1) Fraud is defined as an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person. Fraud is dependent upon evidence that must substantiate misrepresentation with intent to illegally obtain services, payment, or other gains.

(2) Code of Alabama (1975) Section 22-1-11 makes it a felony offense to falsify a claim or application for payment of Medicaid benefits or offer, pay, solicit or receive kickbacks, bribes, or rebates for services. Convictions for any of these felonious actions could result in a fine of $l0,000 or imprisonment for one to five years for each violation.

(3) Providers participating in the Alabama Medicaid Program shall make available, free of charge, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse and/or other deliberate misuse of the Medicaid program.

(4) The Medicaid Fraud Control Unit of the Attorney General's Office may refer providers to Medicaid for administrative sanctions because:

(a) The dollar amount of the fraud involved does not warrant the expense of prosecution; or

(b) Evidence of willful intent to defraud is lacking, although evidence of abuse is present.

(5) Program abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care; provided however, that any finding by the state survey agency of non-compliance by a nursing facility with conditions of participation shall not be considered program abuse under this definition or the examples below. Remedies for such non-compliance are governed by Rule 560-X-l0.~~25~~ 27 of this Code. Nothing in this definition is intended to imply that disputes arising from routine provider reviews or audits necessarily constitute program abuse. Following are some examples of program abuse as defined by the Alabama Medicaid Agency:

(a) Over-utilizing the Medicaid program by furnishing, prescribing, or otherwise causing a recipient to inappropriately receive service(s) or merchandise which is not medically necessary or not otherwise required or requested by the recipient, or not generally provided private pay patients;

(b) Receiving disciplinary action by any state licensing authority which restricts or modifies a provider's license;

(c) Rebating or accepting a fee or portion of a fee or charge for a

Medicaid patient referral;

(d) Submitting a false application for provider status;

(e) Charging recipients for services over and above that paid for by Alabama Medicaid Agency;

(f) Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from Medicaid;

(g) Failing to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments received from the Medicaid fiscal agent; or

(h) Being in a status of less than good standing with a professional licensing, peer review, or similar organization governing the provider's practice.

(2) The following types of administrative sanctions may be imposed as a result of program abuses or fraud by providers:

(a) Provider warning letters for those instances of abuse that can be satisfactorily settled by an informal correspondence process;

(b) Suspension of payments to a provider in accordance with 42 C.F.R. 455.23 upon a ~~receipt of reliable evidence (such as indictment or similar legal action)~~determination by the Medicaid Agency of a credible allegation of fraud ~~that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program~~;

(c) Suspension of payments when a provider does not voluntarily repay improper payments; or for large repayments which have been scheduled for installments, or withholding payments of pending claims, as well as future claims, for application to overpayments owed;

(d) Review of provider's claims prior to payment;

(e) Restriction of provider's Medicaid participation to a specified setting or specified conditions;

(f) ~~Suspension~~ Exclusion of provider's Medicaid participation for a specified time period; and/or

(g) Termination of provider's Medicaid participation.

(3) Restitution of improper payments made to the provider by the Medicaid program may be pursued in addition to any administrative sanctions imposed.

(4) The decision as to the sanction to be imposed shall be at the discretion of the Deputy Commissioner(s) of Medicaid based on the recommendation(s) of the Utilization Review Committee and/or the written policy of the Program Integrity Division.

(5) The following factors shall be considered in determining the sanction(s) to be imposed:

(a) Seriousness of the offense(s);

(b) Extent of violations and history of prior violations;

(c) Prior imposition of sanctions;

(d) Provider willingness to obey program rules;
(e) Actions taken or recommended by peer review groups or licensing boards; and
(f) Effect on health care delivery in the area.

(6) Medicaid shall initiate proceedings to ~~suspend~~exclude or terminate any provider that has been:
(a) Convicted of defrauding the Medicaid program or convicted of a crime related to delivery of medical care or services;
(b) ~~Suspended~~Excluded or terminated from the Medicare program for fraud/abuse; or
(c) Suspended or terminated from practice by his professional licensing authority.

(7) An administrative sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances.

(8) ~~Suspension~~ Exclusion or termination from participation of any provider shall preclude Medicaid from making payment for any item or service furnished by or at the medical direction or on the prescription of such provider on or after the effective date of the exclusion when a person furnishing the service knew, or had reason to know, of the exclusion.

(9) No clinic, group, corporation, or other association, which is a provider of services, shall submit claims for payment to the fiscal agent for any services or supplies provided by a person within such organization who has been ~~suspended~~ excluded or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the ~~suspension~~ exclusion or termination.

(10) When a provider has been sanctioned, Medicaid shall notify, as appropriate, the applicable professional society, licensing authority, the Attorney General's Medicaid Fraud Control Unit, federal agencies, appropriate county departments of social services, and the general public of the sanctions imposed.

(11) A notice setting forth the violations and the provider's rights to an administrative hearing shall be sent to the provider at least ten days prior to the effective date of such sanction except for sanctions as listed in (6)(a) and (b).

Author: Jacqueline G. Thomas, Director, Program Integrity Division
Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Parts 401, 431, 455, 456, State Medicaid Manual 11420.6M.

History: Rule effective October 1, 1982. Amended December 10, 1987; November 10, 1988; March 15, 1994; and March 26, 1996. Effective date of this amendment June 11, 1996. **Amended:** Filed July 17, 2018.