



TENNCARE POLICY MANUAL

Policy No: PI 12-001	
Subject: Credible Allegation of Fraud	
Approval: <i>D. J. Guzman</i>	Date: 3-16-12

PURPOSE:

Recent changes made by the Affordable Care Act require states to suspend payments to providers in cases involving an investigation of a credible allegation of fraud.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
- 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.

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

- Firsthand knowledge
- Corroborating witness

¹ 42 CFR § 455.23.

- Witness conflict (disgruntled employee)
- Prior bad acts
- Pattern of bad acts
- Documentary proof
- Admission by provider
- Expert opinion
- Indictment by a court of competent jurisdiction²

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. Those cases that are determined to represent possible credible allegations of fraud are referred to the Medicaid Fraud Control Unit (MFCU) in accordance with 42 CFR 455.21(a)(1).
2. In Tennessee, the MFCU is authorized by T.C.A § 71-5-2508. It is “separate and distinct” from the State Medicaid agency and is located within the criminal investigation division of the Tennessee Bureau of Investigation (TBI).

The referral to the MFCU requires that the provider’s payments be suspended based on a credible allegation of fraud, in accordance with 42 CFR § 455.23, unless an exception for good cause is warranted. Referrals to the MFCU contain all the information listed in the “minimum criteria” of the CMS-MIG Performance Standard.³

2. If the referral is accepted by the MFCU, the Bureau takes steps to suspend provider payment. The suspension can be a full suspension for all claims submitted by the provider or a partial suspension for only certain services.
3. The first step is to determine whether there is good cause not to suspend payment or good cause to suspend payment only in part.
 - a. Reasons that may constitute “good cause” not to suspend payment are listed in Rule 1200-13-18-.02(19).
 - b. Reasons that may constitute “good cause” to suspend payment only in part are listed in Rule 1200-13-18-.02(20).
4. Assuming that no “good cause” situation is determined to exist, the next step is to provide written notice to the provider of the suspension of payments. See Rule 1200-13-18-.05(2). It

² TennCare Rule 1200-13-18-.02.

³“CMS-MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit.” See <http://www.cms.gov/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf>.

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.

The contents of the notice, including notification of provider appeal rights, are described in Rule 1200-13-18-.05(3) and (6).

5. Provider appeals of suspensions are conducted in accordance with Rule 1200-13-18-.01.
6. Suspensions of payment are temporary and shall end when either of the conditions identified in Rule 1200-13-18-.05(5) are met.

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Audit and Program Integrity
Office of General Counsel

REFERENCES:

<http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=15Oh5b/18/2/0&WAIAction=retrieve>
42 CFR §§ 455.21 and .23

<http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm>
Tennessee Rule 1200-13-18

Original: 01/05/12: SMB
Reprinted for Dennis Garvey's signature / No changes: 03/16/12: AB