A.11.0

County Medical Services (CMS) Fraud Referrals

General

This section contains procedures for handling fraud referrals for the CMS Program.

When a CMS case is established using the CMS IT system, all documentation or verifications used to determine eligibility to and level of coverage within the CMS Program, including CMS forms completed by the patient and eligibility staff, must be imaged and saved into the CMS IT System.

A.11.1

Definition of Fraud

Definition

Fraud exists when an applicant on behalf of him/herself or others, has:

A. Knowingly and with intent to deceive or defraud made a false statement or representation to become certified for CMS.

B. Knowingly and with intent to defraud failed to disclose a fact which, if disclosed, could have resulted in a denial of CMS.

C. Knowingly and with intent to deceive or defraud accept benefits to which he/she was not entitled.

D. Made statements which he/she knew to be untrue for the purpose of avoiding denial of CMS.

A.11.2

Policy

A. Policy

The State DHS Investigators investigate the possibility of fraud in the Medi-Cal Program. However, CMS is a county program, which is not within the State Investigator's jurisdiction. A worker in the county CMS Program, assigned to the CMS Eligibility Unit, has the responsibility of receiving CMS fraud referrals and investigating the situation to determine the facts. Workers first use investigative interviewing techniques to resolve unclear, conflicting or inconsistent

information. If the worker is unable to resolve the issues and determine eligibility, then a referral is appropriate. On applications, the Fraud worker recommends what action the worker should take. On certifications, the Fraud worker determines if an overpayment has occurred and sets up a repayment plan as necessary.

A.11.3

Referrals Procedures

A. Before Certification

When workers cannot resolve inconsistencies in information given by an applicant, they send an email with the CMS IT referral, and any prior HHSA case record attached to 0-557E, Fraud worker. If the prior HHSA case record is not with the worker, the Fraud worker orders the case from Records Library if the application date was before May 12, 2008, when appropriate. After May 12, 2008, the Fraud worker may view the case on the CMS IT System.

B. Referral After Certification

When workers receive information from an informant, who claims that a CMS beneficiary has fraudulently received coverage, the worker sends an email with the case record (if available), and any evidence to O-557E, Fraud worker. If the worker is alerted by an informant that a beneficiary is misusing a CMS card, this information is also sent to the Fraud worker via email and recorded in the case record. Results of the investigation must also be recorded in the case record.

A.11.4

After Referral

A. Eligible

If all eligibility requirements are met and the verifications are not questionable, the decision to certify may not be delayed pending the response from the Fraud worker. If the worker is ready to certify, and a fraud referral was made at least one week before, the worker calls the Fraud worker to check on the status of the investigation.

B. Not Eligible

If the preponderance of evidence submitted by the applicant indicates ineligibility, the worker will deny. The applicant has the right to appeal the denial.

A.11.5

Investigation

A. Before Certification

The Fraud worker reviews the application, contacts individuals who can verify the facts given by the applicants, and reviews records, e.g., medical records, which can verify facts given. The Fraud worker also accesses available computer information systems. After verifying the facts, the Fraud worker recommends action to either certify or deny. This recommendation is written in the comment section of the case record in the IT System, and the Fraud worker notifies the case worker via email.

If the worker disagrees with the recommendation of the Fraud worker, the worker will discuss the difference of opinion with his/her supervisor and the Fraud worker. If an agreement is not reached, the case will be referred to the HCA Manager who will resolve the difference of opinion through discussion with all parties involved.

B. After Certification

The Fraud worker reviews the case record. If a determination can be made at the initial review that there is no overpayment, the Fraud worker documents the results of the investigation in the CMS IT System. If an overpayment has occurred or additional information is needed to make a determination, the Fraud worker prints and sends a HHSA:CMS-30 to the beneficiary. The HHSA: CMS-30 informs the beneficiary of the information received and requests additional information needed. It advises the beneficiary of the expiration date of the current certification period and that continued use of the CMS program might result in an increase in the overpayment amount. If the patient does not respond or responds and the information provided results in a determination of ineligibility, CMS benefits are to be discontinued.

The Fraud worker requests claim information from the ASO to determine whether an overpayment has occurred. The Fraud worker computes the amount of the overpayment and sends the overpayment notice (HHSA:CMS-31) to the beneficiary. A copy of the overpayment notice is forwarded to the CMS Recovery Analyst. The overpayment amount may need to be recomputed upon the expiration of the

certification period after allowing time for providers to submit claims for payment. The Fraud worker documents the case with the results of the investigation and enters the information as appropriate on the IDX system. If the fraud was reported via a MC 609 referral form, the Fraud worker also writes the results of the investigation in the “Action Taken” section of the case comments and files an electronic copy in the case record.

A.11.6

Provider Fraud

A. Reporting Provider Fraud

Informants who want to report possible provider fraud are referred to the Provider Relations Coordinator at (858) 492-4422.