STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Managed Care Organizations Transmittal No. 82
March 16, 2011

TO: Managed Care Organizations

FROM: Thomas V. Russell, Inspector General
Office of the Inspector General

Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: **CORRECTION** To Managed Care Organizations Transmittal No. 81 "MCO Medicaid Fraud Reporting"

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I. Pre or During Provider Enrollment

A. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit when the MCO denies enrollment or renewal of enrollment of a provider into its network or places limits or restrictions on a provider's participation in the network based on concerns related to fraud, integrity, or patient safety. Please see 42 CFR 1001.1001 for additional guidance.

B. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit, within 20 days of when a provider discloses to the MCO:

1. That a person who has an ownership or controlling interest in the provider, or is an officer, director, partner or an agent or managing employee of the provider; and
2. That a person has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program.

II. Post Provider Enrollment

A. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit any provider who displays statistically significant deviations from peer group billing practices or aberrant billing practices if the MCO believes that the provider has received an overpayment of at least $5,000.00.

Aberrant billing practices may consist of (but are not limited to):

1. Age/Diagnosis Inconsistencies
2. Gender/Procedure Inconsistencies
3. Diagnosis/Procedure Inconsistencies
4. Aberrant Service Density or Service Number
5. Age-Inappropriate Service Inconsistencies
6. Upcoding or unbundling
7. Misuse of Modifiers
8. Aberrant Number of Patients
9. Cosmetic Procedure Inappropriateness

B. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit any provider who, after having been audited or reviewed by the MCO or representative of the MCO, is found to have received an overpayment of at least $5,000.00.

C. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit any provider who is suspected of fraud or abuse.

1. 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.

2. 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 or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

D. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit any provider whom the MCO terminated from its provider network for cause related to fraud or abuse.

E. An MCO must report to the DHMH OIG and the Medicaid Fraud Control Unit if the MCO receives notification of the exclusion of a provider by another health plan.

III. Recipients

An MCO must report to the DHMH OIG any recipient who is suspected of fraud.

IV. Reporting

A. Reports must be sent by email to owensp@dhmh.state.md.us for the DHMH Office of the Inspector General and inathan@dhmh.state.md.us for the Medicaid Fraud Control Unit.

B. Except for I (B), which must be reported within 20 days of occurrence, reports must be sent monthly.

C. When reporting, the MCO must provide:

1. For a provider: the name, location/practice address, and NPI number of the provider, a description of what occurred, including information related to dates, codes billed, status of the MCO's review/audit of the provider, and any other information the MCO believes would assist the OIG or MFCU in its own review of the provider.
2. For a recipient: the name, Medicaid number, and a description of what occurred.

If you have any questions regarding this transmittal, please contact Pamela Owens, Assistant Inspector General, Department of Health and Mental Hygiene, at owensp@dhmh.state.md.us or at 410-767-5784.