Louisiana Medicaid CCN Program

Coordination of CCN Fraud and Abuse Complaints and Referrals

The following set of policies and procedures has been developed to govern the disposition of fraud and abuse complaints along with the coordination of activities between DHH and Coordinated Care Networks (CCNs). Their purpose is to establish policy for coordination and referral of complaints made against healthcare providers providing services under a CCN and members enrolled in a CCN, in accordance with 42 CFR §455.

The Program Integrity Section and the Medicaid Coordinated Care Section will work jointly with the CCNs providing services to the Louisiana Medicaid and CHIP populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate. DHH receives fraud and abuse complaints via four main mechanisms:

- The Medicaid fraud hotline toll free number, 1-800-488-2917;
- U.S. mail, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821;
- Fraud reporting fax line 225-219-4155; or
- DHH's website www.dhh.louisiana.gov/offices/?ID=92 and click on the "Report fraud, abuse or complaints" button.

Coordination Involving Fraud and Abuse Complaints Received by DHH

- If DHH receives a complaint about a CCN member's **eligibility** for Medicaid/CHIP, the complaint is referred within three business days to the Medicaid Eligibility Field Operations Section.

- If DHH receives a complaint about a CCN member's **utilization of benefits**, the complaint is referred within three business days to the appropriate CCN.

- If DHH receives a complaint about a provider contracted with CCN(s), the complaint is referred to Program Integrity and Medicaid Coordinated Care Section for preliminary screening for fraud and abuse and/or referral to the appropriate CCN(s) for action.

Coordination for Fraud and Abuse Complaints Received by CCN

- If the CCN receives a complaint about a member's eligibility for Medicaid/CHIP, the complaint is referred to the Program Integrity Section. The referral is made within three business days.

- If the CCN receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the CCN's fraud and abuse/program integrity plan.

- If the CCN receives a complaint against a health care provider or contractor in its network, the CCN shall investigate in accordance with its fraud and abuse/ program integrity plan.

- The CCN will be required to capture data on complaints they receive and shall send reports to Program Integrity monthly.

Fraud and Abuse Referrals

- If a complaint or the findings of a preliminary investigation give the CCN reason to believe that fraud or abuse of the Medicaid program has occurred, the CCN must report this information to the Program Integrity Section within three (3) business days using one of the four mechanisms described above. Any suspicion or knowledge of fraud and abuse includes, but is not limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or contractors. The CCN should submit all relevant information about the case, including its findings and the details of its investigation through one of the four mechanisms DHH receives complaints.

- Upon suspicion of Medicaid fraud on the part of a member enrolled in a CCN, the CCN will refer the complaint to the Program Integrity Section within three (3) business days with all supporting evidence. .

- The Medicaid Coordinated Care Section will send a copy to Program Integrity of any fraud and abuse reports received from the CCNs within three (3) business days.

- For fraud cases against providers and members either initiated or referred by other Offices within DHH, the Office will inform the CCN and the Medicaid Coordinated Care Section when the case results in a criminal conviction, sanction, loss of benefits, and/or exclusion from the Medicaid program.

Excluded Providers

- The Program Integrity Section will update the Health Care Integrity and Protection Databank (HIPDB) to reflect all permissive and mandatory provider exclusions. The CCN shall be required to query the HIPDB for excluded providers. DHH will allow the CCN to become an authorized agent in order for the CCN to gain access to the HIPDB. Information concerning the data bank can be located at: http://www.npdb-hipdb.hrsa.gov/index.jsp

- CCNs shall also check the Excluded Parties List System (www.EPLS.gov) website and the Office of Inspector General Exclusion Database (http://exclusions.oig.hhs.gov/search.aspx) for excluded providers.

Information Sharing

The CCN's Compliance Offer will meet with the DHH Program Integrity Unit and Attorney General's Medicaid Fraud Control Unit (MFCU) on a quarterly basis to exchange information and collaboration on suspected fraud and abuse occurrences. These meetings may take place in person or via teleconference.