

## **1915(i) Policy**

### **Medicaid Program Integrity & Fraud, Waste, and Abuse 510-08-17**

#### **Program Integrity**

The Medicaid Program Integrity Unit (PIU) is dedicated to carrying out program integrity functions. Within the PIU is the Surveillance Utilization Review Section (SURS) that is a federally mandated program that conducts reviews to safeguard against unnecessary and inappropriate use of Medicaid services. The Code of Federal Regulations 42 CFR § 456.3 stipulates that each State Medicaid Agency utilize a surveillance and review process to protect the integrity of the program. The purpose of this requirement is to avoid unnecessary costs to the program due to fraud, waste, or abuse and assure that eligible individuals receive quality and cost-effective medical care.

Provider and member reviews are a necessary and routine function conducted by the PIU. While the methods for reviews may vary, the desired outcome is always to identify areas that may warrant more attention.

The SURS conducts preliminary reviews which may include ad hoc reviews, member or provider analysis, focused quarterly reviews, or compliance reviews.

In addition to any reviews the PIU may conduct, the Medical Services and Behavioral Health 1915(i) Program Administrators may conduct additional reviews to ensure providers are complying with 1915(i) State Plan Amendment requirements. See the 1915(i) Quality Assurance policy.

Reviews and/or investigations may lead to sanctions, recoupments, referral to law enforcement, the Medicaid Fraud Control Unit (MFCU), or other penalties per NDCC 50-24.1-36 and NDAC 75-02-05.

Some reviews may reveal an error caused by an unknown billing system issue or human error with the provider. These types of situations generally reveal no intent to defraud the Medicaid program.

Claims submitted to ND Medicaid are processed electronically. Although the claims payment system detects and denies claims based on National Correct Coding Initiative (NCCI) edits, the system cannot detect all errors or determine if the claims are properly documented. For this reason, payment of a claim does not mean that the service was correctly billed, or the payment made was correct.

Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment.

If a claim is paid and ND Medicaid later discovers that the services were paid in error, ND Medicaid is required by federal regulations to recover any overpayment regardless of whether the incorrect payment was the result of ND Medicaid error, provider error, or other causes.

#### Key Points

- The provider is ultimately responsible for documentation and accurate billing of services.
- SURS is entitled to recover payments made to providers when a claim was paid incorrectly for any reason.
- Reviews may be subject to five years of claims history except in instance of a credible allegation of fraud in which there is no limitation on the timeframe.
- SURS may withhold payment, suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid provider agreement, federal and state laws, regulations and policies.
- A service authorization does not guarantee payment; a claim may be denied or a payment may be recovered even if a service authorization was obtained.

#### **Fraud, Waste and Abuse**

Fraud, Waste and Abuse investigates instances of suspected member and provider fraud, waste, or abuse.

The SFN 20 Suspected Fraud Referral form must be completed in all instances where there is a suspicion of fraud, waste, or abuse. This form is to be used by a provider, individual, or State/County staff to report suspected fraud, waste, or abuse. The link to the form can be found here: [sfn00020.pdf \(nd.gov\)](#)