ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-4
PROGRAM INTEGRITY DIVISION

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560-X-4-.01 General.

(1) The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, waste and/or abuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, that services are provided by qualified providers to eligible recipients, that payments for those services are correct, and that all funds identified for collection are pursued.

(2) Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency (Medicaid) has designated the Program Integrity Division to perform this function. The division is responsible for detecting fraud, waste, and/or abuse within the Medicaid Program through reviewing paid claims history, reviewing provider and recipient enrollment applications, and conducting field reviews and investigations to determine provider/recipient abuse, waste, and suspicion of fraud. In addition, the division is utilized to aid in program management and system improvement to prevent fraud, waste and/or abuse in the Medicaid Program.

(3) Cases of suspected recipient fraud are referred to local law enforcement authorities for prosecution upon completion of investigation. Cases of a credible allegation of provider fraud and nursing home patient account abuse are referred, upon completion of a preliminary investigation, to the Medicaid Fraud Control Unit in the Alabama Attorney General's Office which was established under Public Health 95-142 and Health and Human

Services guidelines to conduct full investigations for possible prosecution, alleged provider fraud and nursing home patient account abuse in the Medicaid Program.

(4) The Utilization Review Committee (URC) is established under the authority of Code of Alabama (1975) Section 22-6-8. This Committee reviews cases of suspected provider or recipient fraud or abuse and recommends appropriate sanctions. (Refer to sections 560-X-4-.04 and 560-X-4-.05)
Author: Jacqueline G. Thomas, Director, Program Integrity Division
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Parts 431, 455, 456, 1000, 1001, 1001, 1002, State Medical Manual 11420.6M.
History: Rule effective October 1, 1982. Amended effective November 10, 1988. **Repealed and Replaced:** Filed February 7, 1994; effective March 15, 1994. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-4-.02 Purpose.

The purpose of the Program Integrity Division is:

(1) To guard against fraud, waste, and/or abuse of Medicaid program benefits by individual providers and recipients;

(2) To assure that Medicaid recipients receive necessary medical care at a level of quality consistent with that available to general population;

(3) To exercise necessary fiscal control over federal and state tax dollars;

(4) To assure provider and recipient compliance with federal and state Medicaid rules and regulations; and

(5) To assist in the identification of claims processing procedures that may be in conflict with State policy.
Author: Jacqueline G. Thomas, Director, Program Integrity Division
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§431, 455, 456, 1000, 1001, 1002; State Medical Manual 11420.6M.
History: Rule effective October 1, 1982. **Amended:** effective November 10, 1988. **Repealed and Replaced:** Filed February 7, 1994; effective March 15, 1994. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-4-.03 Method.

(1) Acquire, organize, and analyze data.

(2) Present computer results through special reports that will enable Program Integrity to accomplish the following:

(a) Develop a comprehensive statistical profile of health care delivery and utilization patterns.

(b) Reveal suspected instances of potential fraud, waste, and/or abuse by individual practitioners, providers, recipients, or sponsors of recipients.

(c) Provide information indicating the existence of any potential deficiencies in the level of care or quality of services provided under the Medicaid Program.

(d) Provide information indicating the existence of any potential deficiencies in State resolution procedures.

(3) Conduct in-house and on-site reviews/investigations to obtain additional facts and/or evidence to substantiate suspicions or allegations. Alabama Medicaid staff shall properly identify themselves to providers or recipients as representing the Alabama Medicaid Agency. They shall request information that they consider pertinent to the audit/investigation. Request shall be made directly to the provider, administrator, or person designated in charge.

(4) Prepare and present reviews/investigation findings for prosecution, corrective action and/or sanction.

(5) Provide information identifying deficiencies in documented policy and intended application.

(6) Assures that the Medicaid Agency complies with the process for screening providers in accordance with 42 CFR 455 Subparts B and E.

Author: Jacqueline G. Thomas, Director, Program Integrity Division

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§401, 431 et seq., 455 et seq., 456 et seq.; State Medical Manual 11420.6M.

History: Rule effective October 1, 1982. Amended effective November 10, 1988. **Repealed and Replaced:** Filed February 7, 1994; effective March 15, 1994. **Amended:** Filed February 20, 1996; effective March 24, 1996. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-4-.04 Fraud, Waste, And/Or Abuse By Providers.

(1) Fraud is defined as an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person. Fraud is dependent upon evidence that must substantiate misrepresentation with intent to illegally obtain services, payment, or other gains.

(2) Code of Ala. 1975, Section 22-1-11 makes it a felony offense to falsify a claim or application for payment of Medicaid benefits or offer, pay, solicit or receive kickbacks, bribes, or rebates for services. Convictions for any of these felonious actions could result in a fine of $10,000 or imprisonment for one to five years for each violation.

(3) Providers participating in the Alabama Medicaid Program shall make available, free of charge, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse and/or other deliberate misuse of the Medicaid program.

(4) The Medicaid Fraud Control Unit of the Attorney General's Office may refer providers to Medicaid for administrative sanctions because:

(a) The dollar amount of the fraud involved does not warrant the expense of prosecution; or

(b) Evidence of willful intent to defraud is lacking, although evidence of abuse is present.

(5) Program abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care; provided however, that any finding by the state survey agency of non-compliance by a nursing facility with conditions of participation shall not be considered program abuse under this definition or the examples below. Remedies for such non-compliance are governed by Rule 560-X-10-.27 of this Code. Nothing in this definition is intended to imply that disputes arising from routine provider reviews or audits necessarily constitute program abuse. Following are some examples of program abuse as defined by the Alabama Medicaid Agency:

(a) Over-utilizing the Medicaid program by furnishing, prescribing, or otherwise causing a recipient to inappropriately receive service(s) or merchandise which is not medically necessary or not otherwise required or requested by the recipient, or not generally provided private pay patients;

(b) Receiving disciplinary action by any state licensing authority which restricts or modifies a provider's license;

(c) Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;

(d) Submitting a false application for provider status;

(e) Charging recipients for services over and above that paid for by Alabama Medicaid Agency;

(f) Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from Medicaid;

(g) Failing to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments received from the Medicaid fiscal agent; or

(h) Being in a status of less than good standing with a professional licensing, peer review, or similar organization governing the provider's practice.

(6) The following types of administrative sanctions may be imposed as a result of program abuses or fraud by providers:

(a) Provider warning letters for those instances of abuse that can be satisfactorily settled by an informal correspondence process;

(b) Suspension of payments to a provider in accordance with 42 C.F.R. 455.23 upon a determination by the Medicaid Agency of a credible allegation of fraud;

(c) Suspension of payments, when a provider does not voluntarily repay improper payments; or for large repayments which have been scheduled for installments, or withholding payments of pending claims, as well as future claims, for application to overpayments owed;

(d) Review of provider's claims prior to payment;

(e) Restriction of provider's Medicaid participation to a specified setting or specified conditions;

(f) Exclusion of provider's Medicaid participation for a specified time period; and/or

(g) Termination of provider's Medicaid participation.

(7) Restitution of improper payments made to the provider by the Medicaid program may be pursued in addition to any administrative sanctions imposed.

(8) The decision as to the sanction to be imposed shall be at the discretion of the Deputy Commissioners of Medicaid based on the recommendation(s) of the Utilization Review Committee and/or the written policy of the Program Integrity Division.

(9) The following factors shall be considered in determining the sanction(s) to be imposed:

(a) Seriousness of the offense(s);

(b) Extent of violations and history of prior violations;

(c) Prior imposition of sanctions;

(d) Provider willingness to obey program rules;

(e) Actions taken or recommended by peer review groups or licensing boards; and

(f) Effect on health care delivery in the area.

(10) Medicaid shall initiate proceedings to exclude or terminate any provider that has been:

(a) Convicted of defrauding the Medicaid program or convicted of a crime related to delivery of medical care or services;

(b) Exclusion or terminated from the Medicare program for fraud/abuse; or

(c) Suspended or terminated from practice by his professional licensing authority.

(11) An administrative sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances.

(12) Exclusion or termination from participation of any provider shall preclude Medicaid from making payment for any item or service furnished by or at the medical direction or on the prescription of such provider on or after the effective date of the exclusion when a person furnishing the service knew, or had reason to know, of the exclusion.

(13) No clinic, group, corporation, or other association, which is a provider of services, shall submit claims for payment to the

fiscal agent for any services or supplies provided by a person within such organization who has been excluded or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the exclusion or termination.

(14) When a provider has been sanctioned, Medicaid shall notify, as appropriate, the applicable professional society, licensing authority, the Attorney General's Medicaid Fraud Control Unit, federal agencies, appropriate county departments of social services, and the general public of the sanctions imposed.

(15) A notice setting forth the violations and the provider's rights to an administrative hearing shall be sent to the provider at least ten days prior to the effective date of such sanction except for sanctions as listed in (6)(a) and (b).
Author: Jacqueline G. Thomas, Director, Program Integrity Division
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§401, 431, 455, 456; State Medical Manual 11420.6M.
History: Rule effective October 1, 1982. **Amended:** effective December 10, 1987; November 10, 1988. **Repealed and Replaced:** Filed February 7, 1994; effective March 15, 1994. **Amended:** Filed February 20, 1996; effective March 26, 1996. **Amended:** Filed May 7, 1996; effective June 11, 1996. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-4-.05 Fraud, Waste, And/Or Abuse By Recipients Or Sponsors Of Recipients.

(1) Recipient fraud, waste, and abuse cases include, but are not limited to, the following categories:

(a) Drug overutilization or overutilization of services;

(b) Sale, alteration, or lending of the Medicaid card to others for services;

(c) Criminal activity involved in securing medical services (such as forged prescriptions);

(d) Repeated failure to safeguard the Medicaid card;

(e) Collusion with providers for services or supplies;

(f) Providing incorrect information or allowing others to do so in order to obtain Medicaid eligibility;

(g) Failure to reveal to Medicaid the existence of third party insurance, failure to pay to Medicaid funds received from "Third Parties" as required by Chapter 20 of these Codes, or

failure in other respects to cooperate with Medicaid in its effort to secure the State's subrogation rights; or

(h) Failure to report changes which occur in income, living arrangement, or resources.

(i) Inappropriate use of Medicaid voucher payments through the Non-Emergency Transportation Program.

(2) Code of Ala. 1975, Section 22-6-8 requires that a Medicaid recipient who has abused, defrauded or deliberately misused benefits of the program shall immediately become ineligible for Medicaid benefits and shall not again be eligible for Medicaid services for a period of not less than one year and until full restitution is made to the State of Alabama.

(3) All cases of suspected fraud, waste, or abuse in receipt of Medicaid benefits by a recipient or sponsor shall be reviewed by the Program Integrity Division to determine the validity of suspected fraud, waste, or abuse. This determination shall include but not be limited to review of system and/or medical data, and if necessary, interview of the suspect recipient, providers with whom he has been in contact, and others as necessary.

(4) Corrective action suspended fraud, abuse, or deliberate misuse shall include the following:

(a) A warning letter for recipients found to be marginally abusing drugs or other services;

(b) Restriction of benefits to one physician and one pharmacy for recipients found to be overutilizing, misusing, and/or abusing services;

(c) Additional restriction of controlled substances if Agency medical staff determines that a recipient's controlled substances utilization is not supported by medical diagnosis; or

(d) Suspension of Medicaid benefits as authorized by Code of Ala. 1975, Section 22-6-8, if recommended by the URC and approved by the Deputy Commissioners of Medicaid. Initial determinations of fraud, waste, or abuse, of program benefits may result in URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than one year and until full restitution of any misspent funds resulting from such fraud, abuse or deliberate misuse. A second determination of fraud, waste, or abuse, of program benefits by a recipient may result in a URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than two years and until full restitution has been made. Recurring occurrences of

fraud, waste, or abuse, of program benefits may result in a URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than four years and until full restitution has been made.

(5) At least ten days prior to imposing any administrative sanction for fraud, waste, or abuse, the recipient shall be provided with a notice of violation setting forth the reasons for the sanctions and the recipient's rights to an administrative hearing.

(6) When a recipient's eligibility for Medicaid benefits has been suspended due to having committed fraud, waste, or abuse, of Medicaid benefits and the recipient subsequently reapplies for Medicaid benefits during the period of suspension due to pregnancy, the Director of Program Integrity will change the suspended status of the recipient to a restricted status for pregnancy related services only. The recipient's eligibility status will be changed back to suspended on the last day of the month in which their 12-month postpartum period ends.

(7) Recipients placed on restriction will have their utilization of services reviewed at least annually to determine if there has been a change in utilization of drugs or other services. When the determination has been made by medical staff that a restriction status should be continued, the recipient will be notified of the following:

(a) The person for continuation of their restriction status;

(b) Their right to reconsideration of this decision and procedures for requesting such; and

(c) Their right to a fair hearing and procedures for requesting such.

(8) If a recipient loses eligibility while on restriction, they will remain restricted upon reinstatement of eligibility pending review by Medicaid medical staff.

Author: Jacqueline G. Thomas, Director, Program Integrity Division

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §§401, 431, 455, 456; 6th Omnibus Budget Reconciliation Act, §9401, 9407; Code of Ala. 1975, §22-6-8.

History: Rule effective October 1, 1982. Amended effective February 8, 1984; June 10, 1987; April 12, 1988; November 10, 1988; March 14, 1989; October 13, 1989; June 14, 1990; January 13, 1993. **Repealed and Replaced:** Filed February 7, 1994; effective March 15, 1994. **Amended:** Filed February 20, 1996; effective March 26, 1996. **Amended:** Filed February 11, 2003; effective March 18, 2003. **Amended:** Filed September 11, 2018; effective

October 26, 2018. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-4-.06 Medicaid Eligibility Quality Control.

The Alabama Medicaid Agency Quality Control Unit is responsible for monitoring Medicaid eligibility correctness. Through its findings administrators may identify and eliminate or reduce dollar losses by effective corrective action in program operations.

(1) Quality Control shall select a monthly random sample of Medicaid recipients from the computer maintained eligibility file.

(2) The random sample shall be reviewed for eligibility determination errors, policy application, and administrative correctness.

(3) Claims shall be collected on the sample to determine payment and error rate due to eligibility determination errors.

(4) Information gathered from these reviews shall provide the basis for corrective action to reduce erroneous Medicaid payments.

(5) The Department of Human Resources (DHR) has eligibility quality control responsibility for the state supplementation segment of Medicaid eligibles.

(6) The total Medicaid payment error rate is the amount of erroneous claims paid due to client ineligibility in the medical assistance only (MAO), and state supplementation cases.

(7) The Agency shall participate in and conduct Payment Error Rate Measurement (PERM) eligibility reviews once every three-years to produce a national error rate.

(8) A sampling plan will be developed; sampling universe identified with claims payment amounts for the sampled cases.

(9) Information gathered from these PERM reviews shall provide the basis for corrective action to reduce erroneous Medicaid payments.

Author: Jacqueline G. Thomas, Director, Program Integrity Division
Statutory Authority: State Plan; 42 C.F.R. Sec. 401, et seq.

History: New Rule: Filed August 7, 1995; effective September 12, 1995. **Amended:** Filed September 11, 2018; effective October 26, 2018.