PERFORMANCE AUDIT REPORT

Medicaid Provider and Recipient Fraud and Abuse

Report No. 3029

September 2, 2010

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Honorable John Hoeven, Governor

Members of the North Dakota Legislative Assembly

Transmitted herewith is the performance audit report on aspects of Medicaid provider and recipient fraud and abuse. This report contains the results of our review of whether the Department of Human Services adequately identifies and pursues indications of potential Medicaid provider and recipient fraud and/or abuse.

We conducted this audit under the authority granted within North Dakota Century Code Chapter 54-10. Included in the report are the objectives and scope, findings and recommendations, and management responses.

We want to extend our appreciation to the management and staff of the Medical Services Division of the Department of Human Services for their assistance and cooperation during this audit.

Sincerely,

Robert R. Peterson
State Auditor

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Results and Findings

Recommendations addressed in this report are listed in Appendix A. Discussions relating to individual recommendations are included in Chapters 1 through 3.

Surveillance and Utilization Review Process

We determined the Department of Human Services (DHS) needs to make changes to promote a culture in which identifying potential Medicaid fraud and abuse is a high priority. Improvements are needed to ensure an effective surveillance and review process is established to protect the integrity of the Medicaid program. The Surveillance and Utilization Review System (SURS) Unit should be organized outside the control of other Medicaid operations. A review is also necessary to ensure adequate resources exist to perform required functions.

Medicaid Providers

We determined potential Medicaid provider fraud and abuse is not adequately identified and pursued by DHS. DHS should submit a new request to the federal government for a Medicaid Fraud Control Unit waiver. Depending on the outcome of the request, DHS will need to make appropriate changes. Improvements are needed to ensure appropriate action is taken when a provider is suspected of fraud or abuse. We identified improvements are needed with denied claims information received by DHS from an outside vendor. Changes are necessary with the audits/reviews conducted on Qualified Service Providers.

Medicaid Recipients

We identified potential Medicaid recipient fraud and abuse is not adequately identified and pursued by DHS. Changes are needed to ensure appropriate action is taken when a recipient is suspected of fraud or abuse. We identified improvements are needed within DHS with communicating indications of fraud and/or abuse identified with program recipients.

Chapter 1

Surveillance and Utilization Review Process

Introduction

In our review of information to determine whether the Department of Human Services (DHS) adequately identifies and pursues indications of potential Medicaid provider and recipient fraud and/or abuse, we determined improvements were needed. Areas of improvement related specifically to Medicaid providers are addressed in Chapter 2 of this report while information related to Medicaid recipients is addressed in Chapter 3. This chapter identifies significant improvements needed in the surveillance and utilization review process for both Medicaid providers and recipients. Improvements of less significance were communicated in a separate letter to management of DHS.

Improving Culture for Identifying Fraud and Abuse

In our review of information, and based on discussions with several DHS employees, it is apparent the identification of potential Medicaid provider and recipient fraud and abuse is not a high priority of the Department. Rather than appropriately identifying indications of possible fraud or abuse, DHS typically identifies such information as "errors." In our review of information, several indications of potential provider and recipient fraud and abuse were identified. However, DHS did not identify these indications as potential fraud or abuse. For providers, DHS looked at these areas and considered recoupment, education/training, or a combination of both. When DHS identified abusive or possible fraudulent behavior of a recipient, DHS placed the recipient in a "lock-in" program (Coordinated Services Program) in which the recipient is to use one physician and one pharmacy.

Indications of potential fraud and abuse are considered "errors" by DHS rather than potential fraud and abuse.

In review of Medicaid recipient information, we identified a lack of communication within DHS regarding instances of potential recipient fraud and/or abuse. A section of the Medical Services Division was finding indications of potential recipient fraud and abuse and did not appropriately communicate such information to the Surveillance and Utilization Review System (SURS) Unit. In fact, this section indicated to us they had no responsibility for identifying potential fraud and abuse. Also, in discussions with representatives of DHS, it appears certain employees of the Department do not believe a Fraud and Abuse Unit even exists within DHS.

In review of Medicaid provider information, we identified DHS had clear indications of potential fraud and/or abuse and had not expanded their reviews or performed additional work. For example, a DHS review of certain provider claims identified over $8,000 of adjustments were necessary (8 months of claims reviewed). In the letter sent to providers detailing the cause of recoupments or adjustments, it was apparent providers knew, or should have known, the claims submitted were inappropriate. In the letter, DHS stated:

> "Although we assume you and your clinic were aware of Medicaid's non-coverage of this treatment per the provider manual, we still wanted to remind you of this non-coverage."

Based on discussions with DHS employees, there is an apparent lack of training for identifying potential fraud and abuse. A number of employees who are reviewing claims information have received limited to no training on fraud and abuse. DHS has not established appropriate policies and procedures addressing employee responsibilities for the identification of potential fraud and abuse. DHS has not properly identified indications of potential fraud and abuse. Thus, there is a lack of adequate action taken by the Department. As a result, the Department is unable to adequately address whether provider or recipient behavior is in fact fraud or abuse. DHS should ensure indications of potential Medicaid fraud and abuse are properly identified to protect the integrity of the Medicaid program.

Recommendation 1-1

We recommend the Department of Human Services promote a culture of identifying potential Medicaid fraud and abuse. At a minimum, the Department should:

a) Establish adequate policies and procedures for identifying potential Medicaid fraud and abuse including definitions and steps to take when indications of potential Medicaid fraud and abuse are identified;
b) Clearly define employees' responsibilities of identifying potential Medicaid fraud and abuse;
c) Communicate such responsibilities to employees; and
d) Provide adequate training for identifying potential fraud and abuse to employees.

Management's Response

The Department of Human Services agrees that emphasis on promoting a culture of identifying potential Medicaid fraud and abuse is important. The Department has made changes by hiring an individual within the Medical Services Division in 2009 for the purpose of ensuring Medicaid Program Integrity.

a) The Medical Services Division is developing policies and procedures for identifying potential Medicaid fraud and abuse.
b) The Medical Services Division will review Position Information Questionnaires (SFN 2572) for Division staff and will ensure that all appropriate positions have defined responsibilities related to identifying potential fraud and abuse.
c) Once the Division completes the review of the Position Information Questionnaires, any changes or additions in employee expectations will be communicated with staff members.
d) The Department of Human Services continues to support the professional development of staff and will ensure staff attend appropriate workshops and seminars.

Improving Surveillance and Review Processes

DHS has a Surveillance and Utilization Review System (SURS) Unit within the Medical Services Division to implement a surveillance and utilization control program. Currently, there is one administrator, one full-time analyst, and one part-time analyst. These same individuals also comprise the Fraud and Abuse Unit. While the SURS Unit is responsible for performing preliminary investigations of Medicaid fraud and abuse, the Fraud and Abuse Unit should be responsible for conducting full investigations. In our review of information, we identified there is no clear distinction of the work performed by employees as being in relation to either unit. In addition, only the administrator's job description includes information pertaining to work to be performed for the Fraud and Abuse Unit. Based on a review of information and discussions with employees, we identified changes were needed to ensure compliance with federal requirements. The SURS Unit should be organized outside the control of other Medicaid operations. A review of the units is also necessary to ensure adequate resources exist to perform required functions.

Ensuring Compliance with Federal Requirements

42 Code of Federal Regulations (CFR) Section 456.3 requires the State Medicaid Agency to implement a surveillance and utilization control program to protect the integrity of the Medicaid program. The purpose of the surveillance and utilization control program is to avoid unnecessary costs due to fraud and abuse, and ensure Medicaid eligible recipients receive quality medical care.

Indications of potential fraud and abuse which require further review are not properly pursued.

Based on a review of information and discussions with DHS employees, significant improvements in the surveillance and utilization control program are necessary. The SURS Unit is conducting limited to no analytical reviews of data to identify areas for further review. Indications of potential fraud and abuse which require further review are not properly pursued. We concluded DHS is in apparent noncompliance with federal requirements as an effective surveillance and review process has not been established to avoid unnecessary costs to the Medicaid program.

Recommendation 1-2

We recommend the Department of Human Services comply with federal requirements and ensure an effective surveillance and review process is established to protect the integrity of the Medicaid program.

Management's Response

The Department of Human Services agrees. Beginning in February 2011, the Medical Services Division will implement semi-annual data analysis that will allow staff to review Medicaid recipient and provider utilization patterns and determine actions to take for identified outliers.

Making Changes with Organizational Structure

The SURS Unit is located within the Medical Services Division of DHS. The Administrator of the SURS Unit reports to the Utilization Review Unit Administrator, who in turn reports to the Medical Services Division Director. The Medical Services Division Director is involved in the process of determining areas to be reviewed by DHS. The Director also receives the results of reviews and investigations. The Director is responsible for determining the actions to be taken following a review or investigation. In review of actions taken with providers who had submitted inappropriate billings, we identified DHS would recoup Medicaid funds in most instances. However, instances were identified where a determination was made not to recoup Medicaid funds even though the Medicaid funds were expended inappropriately.

Personnel performing utilization review and identifying suspected fraud are not sufficiently organized outside the control of other Medicaid operations.

Guidance is provided from the federal government which auditors are to consider when reviewing the utilization review process. This guidance indicates the personnel performing the utilization review and identifying suspected fraud are to be sufficiently organized outside the control of other Medicaid operations to objectively perform their function. We conclude the SURS Unit is not organized outside the control of other Medicaid operations under the current organizational structure. This could impact the performance of the SURS Unit as well as the determination of actions to be taken with providers and recipients.

Recommendation 1-3

We recommend the Department of Human Services ensure the Surveillance and Utilization Review System Unit is sufficiently organized outside the control of the other Medicaid operations so the Unit can objectively perform its functions.

Management's Response

The Department of Human Services agrees that the reporting structure needs to be reviewed to ensure that SURS functions can objectively be performed. Department Management is reviewing an organizational structure change within Medical Services related to Program Integrity and Utilization Review efforts. The review of this structure will consider the comments made in the recommendation.

Ensuring Adequate Resources Exist

The SURS Unit is staffed with a limited number of personnel which includes an administrator, one full-time analyst, and one part-time analyst. The Fraud and Abuse Unit, which is to conduct full investigations, is comprised of the same individuals. We identified no full investigations were performed by DHS on areas involving potential fraud and abuse. For example, following a quarterly audit in which potential provider fraud and/or abuse was evident, DHS did not conduct a full investigation. Also, when DHS identifies abusive or possible fraudulent behavior of a recipient, no further investigation is performed and DHS places the recipient in a "lock-in" program (Coordinated Services Program) in which the recipient is to use one physician and one pharmacy. Due to the fact no full investigation was performed, it is unclear whether areas were, in fact, fraudulent or abusive. In response to why areas were not fully investigated, DHS personnel indicated a lack of resources exist to further pursue instances of potential fraud or abuse.

DHS personnel indicated a lack of resources to pursue instances of potential fraud or abuse.

Our review of both Medicaid provider and recipient information identified several indications of potential Medicaid fraud and/or abuse which were not further reviewed. Employees of the SURS Unit have been assigned certain responsibilities which could be performed by other employees. Moving these responsibilities to other sections of DHS would provide more time for the SURS Unit employees to perform relevant duties. In order for DHS to ensure an adequate surveillance and utilization control program exists which protects the integrity of the Medicaid program, adequate resources must exist to efficiently and effectively perform assigned responsibilities.

Recommendation 1-4

We recommend the Department of Human Services review staffing of the Surveillance and Utilization Review System Unit and the Fraud and Abuse Unit. At a minimum, the review should:

a) Identify duties/responsibilities of the units' employees which are not a responsibility of the units;
b) Determine whether duties can be reassigned; and
c) Ensure adequate resources exist for fulfilling mandatory responsibilities of the units.

Management's Response

The Department of Human Services agrees. After our review of the SURS unit, if additional resources are needed such resources will be considered in the upcoming budget request.

Ensuring Necessary Knowledge and Skills Exist

The State of North Dakota Single Audit for the two-year period ending June 30, 2008 concluded the new administrator for the SURS Unit (hired in October 2007) was not qualified for the position. Using criteria established by the federal government for determining the necessary skills or knowledge for this position, our office concluded the administrator did not have any professional certification or licenses. Specialized training related to the medical field or Medicaid was insufficient. Our office concluded the individual had no prior work experience in reviewing medical claims or investigating Medicaid fraud. While the administrator has received training in the past two years, the training provided has not been sufficient to allow the administrator to obtain professional certifications or licenses. The training provided does not appear sufficient to provide the necessary knowledge and skills for conducting investigations.

Recommendation 1-5

We recommend the Department of Human Services ensure the administrator of the Surveillance and Utilization Review System Unit has the necessary knowledge and skills to conduct utilization reviews and identify suspected fraud by requiring the administrator to have the necessary qualifications as required by the Medicaid program.

Management's Response

The Department of Human Services agrees that the administrator for the SURS unit does not specifically have the certifications or licenses as pointed out in the recommendation. The Medical Services Division's Utilization Review Unit does employ Certified Coders, a Licensed Pharmacist, and Registered Nurses who work closely with the SURS unit. During the Department's review of the SURS unit, necessary training will be explored.

Making Improvements for Reporting Potential Fraud and Abuse to DHS

In review of information related to how suspected Medicaid fraud or abuse could be reported to DHS, we identified improvements were needed to ensure reporting such information could be done in a convenient manner. Calling the Medical Services Division general information phone number required the caller to choose from four options, none of which identified reporting fraud or abuse. In our review of information, we identified states have a dedicated 1-800 number for reporting suspected Medicaid fraud or abuse as well as states with an option on their website to easily report this information.

Recommendation 1-6

We recommend the Department of Human Services provide appropriate and convenient methods to report potential Medicaid fraud and abuse. The Department should:

a) Establish a dedicated 1-800 number for reporting fraud and abuse and/or add an option to the current Medical Services Division number dedicated to reporting fraud and abuse; and/or
b) Have an online form which can be submitted electronically.

Management's Response

The Department of Human Services agrees. A "Fraud Reporting" section exists on the Department's home page; which contains a toll-free number and e-mail address for reporting suspected fraud. This toll-free number now identifies an option for reporting suspected fraud. In addition, the Medical Services Division is adding an option to the Division's 1-800# and will be adding an option for reporting suspected fraud through the Division's web site.

Chapter 2

Medicaid Providers

Introduction

An objective of this performance audit was to answer the following question:

> "Does the Department of Human Services adequately identify and pursue indications of potential Medicaid provider fraud and/or abuse?"

We determined the Department of Human Services (DHS) does not adequately identify and pursue indications of potential Medicaid provider fraud and/or abuse. This has an impact on the integrity of the Medicaid program. Significant improvements needed by DHS are included in this chapter. Improvements of less significance were communicated in a separate letter to management of DHS.

To determine whether DHS adequately identified and pursued indications of potential Medicaid provider fraud and/or abuse, we:

- Reviewed applicable laws and policies;
- Reviewed case files of selected providers;
- Reviewed 20 audits/reviews conducted on Qualified Service Providers;
- Reviewed information related to 80 adjusted claims;
- Reviewed information provided by the Quality Improvement Organization and selected 35 denials of claims to review;
- Reviewed information from 10 states;
- Reviewed the status of previous recommendations which were applicable to our audit scope; and
- Interviewed selected personnel.

Requesting a New MFCU Waiver

North Dakota is the only state without a MFCU due to a waiver granted in 1994. A waiver may only be granted if the state establishes minimal fraud exists in the state's Medicaid program.

A Medicaid Fraud Control Unit (MFCU) is a single identifiable entity of state government, annually certified by the Secretary of the U.S. Department of Health and Human Services (DHHS). A MFCU may conduct a statewide program for the investigation and prosecution of health care providers which defraud the Medicaid program. Federal regulations allow a MFCU to review recipient fraud only when it involves conspiracy with a provider. In addition, a MFCU may review complaints of abuse or neglect of nursing home residents. A MFCU is charged with investigating fraud in the administration of the Medicaid program. It also provides for the collection, or the referral for collection to the single state agency, any overpayments it identifies in performing its activities. North Dakota is the only state without a MFCU.

Under federal law, each state must have a MFCU unless the state demonstrates to the satisfaction of the Secretary of DHHS a MFCU would not be cost effective. A waiver may only be granted if the state establishes minimal fraud exists in the state's Medicaid program and Medicaid beneficiaries will be protected from abuse and neglect by another agency.

In 1994, North Dakota received a waiver from DHHS and was not required to establish a MFCU. In review of the waiver and the letter from the state to the federal government requesting the waiver, we identified a number of reasons for requesting, and apparently granting the waiver, no longer apply. For example:

There are numerous indications of potential Medicaid provider fraud and abuse within the state.

- The waiver states North Dakota maintains there is minimal fraud in the Medicaid program. Based on our review of information, there are numerous indications of potential Medicaid provider fraud and abuse within the state. Currently, DHS does not adequately identify such indications as potential fraud or abuse and is not performing adequate investigations to determine whether actual fraud or abuse occurred. We identified several areas of apparent fraudulent behavior in a limited review of information. In the limited reviews performed by DHS on providers, inappropriate billing practices were identified which resulted in attempts by DHS to recoup Medicaid funds. Quarterly audits conducted by DHS are based on limited time periods of data and have identified Medicaid funds which needed to be recouped. For example, in one quarterly audit, DHS reviewed a random selection of 10% of certain types of claims for a 3 month time period. DHS identified over $5,000 was to be adjusted. If DHS was to review 100% of these claims for a 12 month time period, the adjustment may have totaled $200,000. Based on information from DHS, approximately $50,000 per year is identified for recoupment from Qualified Service Providers (approximately 80 audits/reviews performed by DHS per year).
- The waiver states the Surveillance and Utilization Review System (SURS) Unit of the State Medicaid Agency identifies and investigates fraud as part of its function and refers cases to the State Attorney General for further investigation and prosecution. Based on our review of information, the SURS Unit is not currently conducting adequate investigations and, as a result, is not referring cases for further investigation and prosecution.
- The letter requesting the waiver identified North Dakota does not have a large Medicaid population compared to most states with fraud control units in place. The letter identifies approximately 39,000 Medicaid recipients and a provider population of 8,000. Based on information provided by DHS, the current number of Medicaid recipients is approximately 62,000 and the provider population is over 18,000. The number of recipients is anticipated to grow significantly under the new health care reform legislation.

The waiver received in 1994 is based on information and circumstances which have significantly changed.

The waiver requested and received in 1994 is based on information and circumstances which have significantly changed. DHS should submit a new request for a waiver based on current information and circumstances. Depending on the outcome of this request, the following will need to take place:

- If a new waiver is not granted by the federal government, appropriate action will be required to establish a MFCU within the state. Typically, such a unit would be established within the Office of the Attorney General. If established, the federal government will pay for 90% of the eligible expenses for the first three years. After this time, 75% of the expenses are eligible for federal reimbursement. The state's percent of expenditures required to be paid could come from funds received through global case processes (such as multi-state cases against pharmaceutical companies) and/or with funds recovered from investigations. Thus, additional general funds may not be required to establish a MFCU.
- If a new waiver is received, DHS must still make appropriate changes to ensure adequate resources exist to efficiently and effectively investigate and refer Medicaid provider fraud and abuse. When asked why potential Medicaid provider fraud and abuse were not further reviewed or investigated, DHS indicated a lack of appropriate resources to further pursue these areas.

Additional general funds may not be required to establish a MFCU.

Recommendation 2-1

We recommend the Department of Human Services submit a new request to the federal government for a Medicaid Fraud Control Unit waiver. Based on the determination from the federal government, the Department should:

a) Take appropriate action to establish a Medicaid Fraud Control Unit in the state of North Dakota; or
b) Ensure adequate resources are made available to efficiently and effectively investigate and refer Medicaid provider fraud and abuse.

Management's Response

The Department of Human Services does not agree that a new waiver is needed as we contacted the federal government during the 2009 DHS Financial Audit, and received confirmation that the waiver did not have an expiration date. However, the Department will contact the Federal government to inquire to what extent conditions need to change which would require a new waiver request to be submitted. Appropriate action will be taken after information is provided by the federal government.

Ensuring Appropriate Investigations and Referrals

42 Code of Federal Regulations (CFR) Section 455.15 requires the State Medicaid Agency to take action following a preliminary investigation if a provider is suspected of fraud or abuse. Under this CFR, DHS is required to conduct a full investigation or refer the case to the appropriate law enforcement agency if a provider is suspected of fraud or abuse.

Based on a review of "investigation" files, quarterly audit information, and interviews with DHS employees, there does not appear to be adequate investigations of providers performed by DHS. While DHS had opened case files on certain areas where a concern or inappropriate behavior was identified, no actual full investigation was performed. In addition,

While DHS had opened case files on certain areas where a concern was identified, no actual full investigation was performed.

the results from quarterly audits identified indications of potential fraud and/or abuse and no further investigation took place. At the end of the review performed for one quarterly audit, DHS sent letters to providers detailing the cause of recoupments/adjustments and stated:

> "Although we assume you and your clinic were aware of Medicaid's non-coverage of this treatment per the provider manual, we still wanted to remind you of this non-coverage."

It is clear providers knew, or should have known, the claims being submitted were inappropriate. No further investigation or work was done by DHS in this area. Also, interviews with DHS employees identified examples of inappropriate claims being submitted, providers re-submitting claims multiple times, and other actions of providers which appear to be indicative of potential fraud or abuse. Very limited, to no, investigations were conducted relating to these instances.

As identified in Chapter 1 of this report, DHS does not properly identify inappropriate billings or other unacceptable provider actions as indications of potential fraud or abuse. As a result, proper investigations are not conducted. In the limited instances in which attempts were made by DHS to investigate inappropriate provider actions, we concluded DHS did not conduct adequate investigations. Due to this, it appears DHS is in noncompliance with federal requirements.

Recommendation 2-2

We recommend the Department of Human Services comply with federal requirements and take appropriate action when a provider is suspected of fraud or abuse following a preliminary investigation. When applicable, the Department should:

a) Conduct full investigations; or
b) Refer the case to an appropriate law enforcement agency.

Management's Response

The Department of Human Services agrees. The Medical Services Division will follow federal requirements and establish policies and procedures for conducting investigations of Medicaid providers and referring cases to appropriate law enforcement agencies.

Improving Monitoring and Investigation of QIO Information

DHS has entered into a contract with a vendor to be the authorized Quality Improvement Organization (QIO) for the Medicaid program. This vendor reviews inpatient hospital services provided to Medicaid patients in the state and determines if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. If QIO determines the claims for services are inappropriate, DHS is notified of the denial.

The vendor provides a June 30 fiscal year-end report to DHS identifying data related to the work performed. Based on information from the vendor, the following was identified:

- Fiscal year 2009: 137 cases denied (4,004 reviewed)
- Fiscal year 2008: 104 cases denied (3,571 reviewed)
- Fiscal year 2007: 149 cases denied (2,754 reviewed)

In review of the information from QIO for the fiscal year 2009 denied cases, we identified indications of inappropriate billing which were indicative of potential fraud or abuse. For example, providers were identified as billing for services at a higher level of care than what was needed as well as billing for a level of care which was not supported by documentation (such as billing for acute care when supporting documentation indicated it was a psychiatric stay). Of the 137 cases denied in fiscal year 2009, QIO identified 19 were "Billing Denials." In review of actions taken by DHS on these denials, we identified two denials required no adjustments as the original claim was denied in one case and the provider had submitted a new claim on the service provided for the other case. Of the remaining 17 cases, we identified adjustments were made to recover approximately $18,800.

Certain cases denied by QIO were indicative of potential fraud or abuse. No information was communicated to the SURS Unit for appropriate follow-up review or investigation.

The information provided by QIO to DHS on denied cases is not monitored to review for repetitive or inappropriate provider behavior. We requested from DHS the supporting documents from QIO for the 137 denied cases in fiscal year 2009. DHS was only able to provide information on 133 cases. The information received from QIO is not communicated to the SURS Unit for appropriate follow-up review and/or investigation.

Recommendation 2-3

We recommend the Department of Human Services make improvements with the denied claims information received from the Quality Improvement Organization. At a minimum, the Department should:

a) Effectively monitor and identify patterns of inappropriate billings; and
b) Ensure inappropriate billing information is provided to the Surveillance and Utilization Review System Unit.

Management's Response

The Department of Human Services agrees and is working with the Quality Improvement Organization to develop a routine report of provider billing and documentation errors in order to analyze any trends. The results of the routine reports will be shared with the Surveillance and Utilization Review System Unit staff, who will initiate follow up with providers identified.

Improving the Post-Payment Review Process

42 CFR Section 456.23 requires the State Medicaid Agency to have a post-payment review process. The process must allow state personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria. The process must identify exceptions so the agency can correct misutilization practices of recipients and providers. DHS established a quarterly audit process in January 2009 to comply with federal requirements for post-payment review processes for providers. DHS identifies a prospective provider area to review, obtains claims data and supporting documentation from selected providers, and performs a review of information.

The amount of inappropriately paid funds identified could be significantly higher if DHS were to review additional data or expand their review.

DHS had completed 5 quarterly audits at the time of our review. Three of the quarterly audits identified adjustments were needed totaling approximately $26,000. These adjustments were required due to inappropriate billings submitted by the providers. The amount of adjustments could be significantly higher if DHS were to review additional data or expand the review. For example, DHS identified adjustments totaling $5,000 were necessary based on a review of 10% of certain claims for only a three month time period. If the errors identified were projected to the entire population of claims in this area for one year, the total adjustment required could exceed $200,000.

Based on discussions with DHS personnel, it appears individual employees at DHS are frequently performing their own informal reviews without formal recordkeeping or the assistance of the rest of the Utilization Review team. These reviews could be coordinated and/or documented in a manner which would enhance consistency and effectiveness as well as ensure compliance with federal requirements.

Recommendation 2-4

We recommend the Department of Human Services improve the post-payment review process of Medicaid providers to ensure fraud and abuse are effectively identified.

Management's Response

The Department of Human Services agrees and will take measures to continually improve the post payment review process.

Improving Monitoring and Investigation of Ambulance Providers

As part of our review, we requested DHS provide a list of adjustments made to claims for selected provider areas. In review of adjustments for transportation claims, we identified DHS had inappropriately processed adjustments for an ambulance provider. This provider had submitted a request for a higher rate of pay for previously paid claims. DHS claims processing staff approved the request and made the adjustments. In discussions with DHS, it is apparent the adjustments should not have been made. In review of adjustment information, it appears 38 adjustments may have been made inappropriately resulting in overpayment of Medicaid funds by $3,275.

DHS employees identified ambulance provider claims as a high-risk area.

Based on discussions with DHS employees, ambulance provider claims are a high-risk area. In addition, data analysis of ambulance claims

performed by a local university in 2007 identified several ambulance providers had submitted claims with indications of "upcoding" to receive a higher rate of pay from Medicaid. It appears no additional review of the claims was performed.

Recommendation 2-5

We recommend the Department of Human Services take appropriate action with ambulance provider claims to ensure Medicaid funds are properly expended. At a minimum, the Department should:

a) Ensure recovery of inappropriately paid claims;
b) Perform an analytical review of ambulance provider claims; and
c) Conduct necessary investigations of suspected provider fraud or abuse.

Management's Response

The Department of Human Services agrees.

a) The Medical Services Division will recover payments from the claims identified during the audit as being paid inappropriately.
b) The Medical Services Division will increase the number of reviews completed for ambulance service claims and will prepare analytical reports of ambulance claim data. The Department must remain mindful when conducting reviews of ambulance service claims which must be conducted within the provisions of NDCC 50-24.1-15.
c) The Medical Services Division will conduct investigations of suspected provider fraud and abuse, as identified through the analytical review of ambulance provider claims.

Improving Monitoring and Investigation of Quality Service Providers

Qualified Service Providers (QSPs) are individuals or agencies who provide in-home services to clients who aren't able to perform necessary tasks but don't want to be placed in an assisted living facility. QSP's are considered independent contractors of the state who have met certain competency standards required to provide services to eligible clients. QSP services may be paid with Medicaid funds under a Medicaid waiver and the Medicaid State Plan.

DHS is identifying a number of significant QSP billing problems which are indicative of potential fraud or abuse. No information is being forwarded to the SURS Unit.

Home and Community Based Services (HCBS) employees of DHS perform audits/reviews of QSPs. For newly enrolled QSPs, HCBS employees monitor bills submitted for the first 3 months. After this time, an audit/review of the QSP is initiated when problems are identified through a review of claims or from calls by recipients or other QSPs. We received a listing of QSP audits/reviews performed on QSPs who were paid with Medicaid funds. Based on our review of 20 QSP audits/reviews, we identified DHS is detecting a number of significant billing problems. These problems include billing for services while the recipient is hospitalized, billing for services not documented, billing for more units of service than documented, and billing services for multiple recipients at the same time. For example, a QSP who had stopped providing services to a client continued to bill, and be paid for, services. Also, another QSP was identified in 2008 as billing for services while the client was hospitalized. This same QSP was identified in 2010 as again

billing for services while the client was hospitalized. In the review performed in 2008, HCBS stated the QSP was "doing the same tasks at the same time every day and this is unrealistic." Based on discussions with HCBS employees and management, there are indications of potential fraud and/or abuse with QSPs. No information is being forwarded to the SURS Unit.

DHS identified approximately 80 audits/reviews are performed per year. The audits/reviews identified over $160,000 of inappropriate billings in the last 3.5 years and attempts were made to recoup the Medicaid funds. Currently, these audits/reviews are done only when a problem is brought to the attention of HCBS. There does not appear to be a proactive analytical review of data to identify trends or other potential problem areas.

Recommendation 2-6

We recommend the Department of Human Services make improvements with the audits/reviews conducted on Qualified Service Providers. At a minimum, the Department should:

a) Conduct analytical reviews of data to identify areas to audit/review;
b) Ensure adequate resources exist to conduct audits/reviews of Qualified Service Providers; and
c) Forward indications of Medicaid fraud and abuse to the Surveillance and Utilization Review System Unit, as applicable.

Management's Response

The Department of Human Services agrees.

a) The Medical Services Division has developed a template and process to ensure that Qualified Service Provider claims data is analyzed to identify areas that warrant further audit and review.
b) After our review of the SURS unit, if additional resources are needed such requests will be considered in the upcoming budget request.
c) Medical Services will implement procedures to ensure that the Home and Community-Based Services staff inform the Surveillance and Utilization Review System Unit of all indications of suspected Qualified Service Provider fraud and abuse.

Establishing Policies and Procedures

In a review of policies and procedures established by DHS related to Medicaid provider fraud and abuse, we identified improvements were needed. There is a lack of adequate policies and procedures for investigating suspected Medicaid provider fraud and abuse. Minimal information exists addressing how full investigations are performed.

42 CFR Section 455.13 requires the State Medicaid Agency to have procedures developed in cooperation with state legal authorities for referring suspected fraud cases to law enforcement officials. Adequate procedures have not been developed for referring Medicaid provider fraud to the appropriate law enforcement officials.

Recommendation 2-7 We recommend the Department of Human Services establish policies and procedures for conducting investigations of potential Medicaid provider fraud and/or abuse.

Management's Response The Department of Human Services agrees. The Medical Services Division has begun work to establish policies and procedures for conducting investigations of Medicaid providers.

Recommendation 2-8 We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid provider fraud.

Management's Response The Department of Human Services agrees. The Medical Services Division has begun work to establish policies and procedures for referring suspected Medicaid provider fraud.

Improving Practices Related to Sanctions

North Dakota Administrative Code (NDAC) Chapter 75-02-05 outlines the sanctions DHS may apply to Medicaid providers. In a comparison of NDAC to Code of Federal Regulations (CFR) requirements, it appears NDAC is outdated. For example, NDAC Chapter 75-02-05 has not been modified since 1980, NDAC references one CFR which no longer exists, and NDAC does not address all situations in which civil money penalties can be applied.

DHS does not sanction providers. Thus, there is no deterrent to reduce inappropriate behavior.

Based on discussions with DHS employees, it appears DHS does not sanction providers. When inappropriate billings and services are identified by DHS, an attempt to recoup funds and/or provide education is made. Thus, there is no deterrent to stop or limit inappropriate behavior. With no deterrent to reduce inappropriate behavior, such behavior can be expected to continue.

Recommendation 2-9 We recommend the Department of Human Services review practices related to sanctions of Medicaid providers and make appropriate changes to use such options when applicable. At a minimum, the Department should:

a) Review and update North Dakota Administrative Code Chapter 75-02-05 and ensure rules are consistent with the Code of Federal Regulations requirements; and
b) Ensure civil penalties and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse.

Management's Response The Department of Human Services agrees.

a) The Medical Services Division will review and propose updates (as necessary) to North Dakota Administrative Code Chapter 75-02-05.
b) The Medical Services Division will ensure civil penalties and other sanctions are imposed as applicable.

Chapter 3

Medicaid Recipients

Introduction

An objective of this performance audit was to answer the following question:

> "Does the Department of Human Services adequately identify and pursue indications of potential Medicaid recipient fraud and/or abuse?"

We determined the Department of Human Services (DHS) does not adequately identify and pursue indications of potential Medicaid recipient fraud and/or abuse. This has an impact on the integrity of the Medicaid program. Significant improvements needed by DHS are included in this chapter. Improvements of less significance were communicated in a separate letter to management of DHS.

To determine whether DHS adequately identified and pursued indications of potential Medicaid recipient fraud and/or abuse, we:

- Reviewed applicable laws and policies;
- Reviewed case files of selected recipients
- Reviewed 50 recipients placed into the Coordinated Services Program (CSP);
- Reviewed 14 recipients identified for placement into CSP who were not placed into CSP;
- Reviewed information from 10 states;
- Reviewed the status of previous recommendations which were applicable to our audit scope; and
- Interviewed selected personnel.

Coordinated Services Program

The Coordinated Services Program (CSP) is a lock-in program for Medicaid recipients. When a recipient is placed in CSP, the recipient selects, and DHS approves, one physician and one pharmacy which the recipient is to use for their health care needs. Recipients are placed in CSP due to abusive behavior (such as pharmacy shopping) and/or if DHS determines the recipients require closer monitoring of the care they are receiving. Recipients are notified of their placement in CSP and have the right to appeal being placed in the program. Non-pharmacy claims involving recipients in CSP are reviewed by DHS prior to payment. The two employees performing these reviews are within the Surveillance and Utilization Review System (SURS) Unit.

DHS identified approximately 700 recipients in CSP. DHS identified the number of recipients in CSP has been increasing consistently. Once placed in CSP, very few recipients are removed from the program.

Ensuring Appropriate Investigations and Referrals

DHS has not taken action required by federal law when a recipient is suspected of fraud or abuse.

42 Code of Federal Regulations (CFR) Section 455.15 requires the State Medicaid Agency to take action following a preliminary investigation if a recipient is suspected of fraud or abuse. Under this CFR, DHS is required to conduct a full investigation if there is reason to believe the recipient has abused the Medicaid program. Also, DHS is required to refer the case to the appropriate law enforcement agency if there is reason to believe the recipient has defrauded the Medicaid program. In our review of 50 CSP files as well as "investigation" case files opened by DHS, we conclude the Department has not conducted full investigations when abusive behavior is identified and has not referred cases to the appropriate law enforcement agency when there was apparent fraudulent behavior.

As addressed in Chapter 1 of this report, DHS does not properly identify potential Medicaid recipient fraud and abuse. We identified DHS will place recipients in CSP rather than conduct investigations or refer information as required. While this program allows DHS to monitor the recipient, DHS appears to be in noncompliance with federal regulations.

Recommendation 3-1

We recommend the Department of Human Services comply with federal requirements following preliminary investigations of Medicaid recipients. When applicable, the Department should:

a) Refer the case to an appropriate law enforcement agency if there is reason to believe a recipient has defrauded the Medicaid program; and
b) Conduct a full investigation of abuse if there is reason to believe a recipient has abused the Medicaid program.

Management's Response

The Department of Human Services agrees.

a) The Medical Services Division is developing procedures for ensuring Medicaid cases are referred to appropriate law enforcement agencies when fraud and abuse are suspected.
b) The Medical Services Division is developing procedures for ensuring full investigations are completed if program abuse is suspected.

Improving Communication of Identified Fraud and Abuse

Notification is not provided to appropriate divisions and units of DHS when indications of recipient fraud and/or abuse are identified.

In review of information and discussions with DHS personnel, we identified information related to recipient fraud and abuse is not shared between units or other DHS programs. For example, DHS has a Quality Control function which reviews information at the county level to determine whether counties have complied with DHS policies in determining the eligibility of clients for public assistance programs. We reviewed errors in eligibility determined by Quality Control and identified instances which were indicative of potential fraud. For example, one review identified the client had failed to report a job with significant income (resulted in the understatement of recipient liability by $1,175 for the month). None of this information was communicated to the SURS Unit. Clients who will abuse the system or commit fraud to become

eligible for a program are a higher risk to abuse or commit fraud when placed in the program.

Medicaid recipients may also be receiving benefits from other programs administered by DHS such as the food stamp program (SNAP) or Temporary Assistance for Needy Families (TANF). Information related to these clients should be shared among DHS divisions and units as a client's abusive or fraudulent behavior in one program could be occurring in another program. The work performed by DHS related to client fraud and/or abuse is decentralized with each division conducting their own work. Centralizing this function could provide for a more effective process.

Recommendation 3-2

We recommend the Department of Human Services make improvements communicating indications of fraud and/or abuse identified with any program recipient. At a minimum, the Department should:

a) Ensure the Surveillance and Utilization Review System Unit and/or Fraud and Abuse Unit are notified of all indications of potential Medicaid recipient fraud and/or abuse;
b) Communicate indications of fraud and/or abuse to other applicable program areas; and
c) Analyze the benefits of centralizing fraud and abuse information and work for all programs within the Department.

Management's Response

The Department of Human Services agrees.

a) The Medical Services Division will educate staff to ensure that the Surveillance and Utilization Review System Unit are notified of all indications of potential Medicaid recipient fraud and/or abuse.
b) The Medical Services Division will ensure the Surveillance and Utilization Review System Unit notifies other Department program managers (as applicable) of indications of program abuse.
c) By October 1, 2011, the Department will analyze the benefits of centralizing fraud and abuse information and work for all programs in the Department.

Establishing Policies and Procedures

In a review of policies and procedures established by DHS related to Medicaid recipient fraud and abuse, we identified improvements were needed. There is a lack of adequate policies and procedures for investigating suspected Medicaid recipient fraud and abuse. Minimal information exists addressing how full investigations are performed.

42 CFR Section 455.13 requires the State Medicaid Agency to have procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials. Adequate procedures have not been developed for referring Medicaid recipient fraud to the appropriate law enforcement officials.

Recommendation 3-3 We recommend the Department of Human Services establish policies and procedures for conducting investigations of potential Medicaid recipient fraud and/or abuse.

Management's Response The Department of Human Services agrees and is developing procedures for ensuring full investigations are completed if program abuse is suspected.

Recommendation 3-4 We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid recipient fraud.

Management's Response The Department of Human Services agrees and is developing procedures for ensuring Medicaid cases are referred to appropriate law enforcement agencies when fraud and abuse are suspected.

Analyzing Reestablishment of Welfare Fraud Units

As part of our review of Medicaid recipients, we contacted representatives of the two largest county social services offices in the state. Both representatives indicated the counties previously had a resource available to them which assisted the counties in identifying Medicaid fraud and abuse. We identified this resource was the Welfare Fraud Units.

In review of information and discussions with DHS representatives, the Welfare Fraud Units were established in 1994 and in 1997 there were four units in operation. The units performed investigations of potential public assistance fraud. County representatives indicated investigators had a full workload at that time. Funding for these units was not included in the 1999-2001 Executive Budget Recommendation.

Units previously established for investigating public assistance fraud no longer exist.

Potential recipient eligibility fraud information identified by DHS is not pursued by the Department. Instead, the information is provided to the counties to review as the counties determine eligibility for public assistance programs. The two county representatives stated the previous fraud investigators were beneficial to the counties and enabled them to identify and even deter potential Medicaid recipient fraud and abuse.

Recommendation 3-5 We recommend the Department of Human Services conduct a formal cost/benefit analysis to determine if the reestablishment of Welfare Fraud Units within North Dakota is warranted.

Management's Response The Department of Human Services agrees. By October 1, 2011, the Department of Human Services will complete a cost/benefit analysis to determine if the reestablishment of Welfare Fraud Units within North Dakota is warranted.

Improving Requirements for Referring Recipient Errors

DHS Medicaid Program Policy 510-05-10-25 states:

> "All recipient errors must be referred to the states attorney's office with copies to the regional representative and the Estate Recovery Unit at the Department."

A DHS policy requiring all recipient errors identified at the county level be referred to the State's Attorney's Office is unreasonable.

Based on discussions with county social services representatives, it is apparent the county social services offices are not referring all incidents of recipient error to their State's Attorney's Offices. Both DHS and county social services representatives indicated the State's Attorney's Offices are not receptive to all referrals of Medicaid recipient error. Certain incidents of recipient error may be inadvertent or the result of a misunderstanding rather than fraudulent activity. Notifying State's Attorney's Offices of all errors appears unreasonable and inefficient. There is no requirement of the counties to contact the SURS Unit if there is an indication recipient "errors" may involve fraudulent or abusive behavior.

Recommendation 3-6

We recommend the Department of Human Services modify requirements in the Medicaid Program Policy Manual related to county social services offices referring all recipient errors to the State's Attorney's Office. At a minimum, the Department should:

a) Establish criteria for recipient errors which must be reported to the Surveillance and Utilization Review System Unit; and
b) No longer require counties to refer all recipient errors to the State's Attorney's Office.

Management's Response

The Department of Human Services agrees and is revising policy to establish criteria regarding which recipient errors must be reported to the Surveillance and Utilization Review System Unit.

Audit and Medicaid Background Information

Purpose and Authority of the Audit

The performance audit of aspects of Medicaid provider and recipient fraud and abuse was conducted by the Office of the State Auditor pursuant to authority within North Dakota Century Code Chapter 54-10.

Performance audits are defined as engagements that provide assurance or conclusions based on an evaluation of sufficient, appropriate evidence against stated criteria, such as specific requirements, measures, or defined business practices. Performance audits provide objective analysis so management and those charged with governance and oversight can use the information to improve performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability. The purpose of this report is to provide our analysis, findings, and recommendations regarding our limited review of whether the Department of Human Services (DHS) adequately identifies and pursues indications of potential Medicaid provider and recipient fraud and/or abuse.

Background Information

The Medicaid program was authorized in 1966 for the purpose of strengthening and extending the provision of medical care and services to people whose resources were insufficient to meet such costs. Corrective, preventative, and rehabilitative medical services are provided with the objective of retaining or attaining capability for independence, self-care, and support. These services are extended to elderly, blind, or disabled individuals as well as to caretaker relatives and children to the age of 21 years. Funding is shared by federal, state, and county governments, with eligibility determined at the county level. Information provided by DHS identified over 18,000 providers and 62,000 recipients enrolled in the Medicaid Program.

Requirements related to Medicaid fraud and abuse are included in federal law, state law, and DHS policies. Federal requirements stipulate the State Medicaid Agency utilize a surveillance and review process to protect the integrity of the program. The purpose is to avoid unnecessary costs due to fraud or abuse and ensure Medicaid eligible recipients receive quality medical care. DHS has a Surveillance and Utilization Review System (SURS) Unit located within the Medical Services Division for implementing a surveillance and utilization control program.

Medicaid Fraud and Abuse Definitions

We reviewed federal and state laws, the North Dakota Medicaid State Plan, and other information to identify a definition of Medicaid fraud and Medicaid abuse which would be used for this audit. Based on our review, the following definitions were used (DHS agreed to the following definitions):

- 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 and state law.

- 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.

Objectives of the Audit

The objectives of this performance audit are listed below:

"Does the Department of Human Services adequately identify and pursue indications of potential Medicaid provider fraud and/or abuse?"

"Does the Department of Human Services adequately identify and pursue indications of potential Medicaid recipient fraud and/or abuse?"

Scope and Methodology

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Audit field work was conducted from the end of October 2009 to the beginning of September 2010. Due to another performance audit conducted by our office, work on this audit was stopped from the middle of February 2010 until the middle of April 2010. The audit period for which information was collected and reviewed was July 1, 2006 through June 30, 2009. In certain instances, additional information was reviewed. This was done, in part, to review necessary information related to selected areas as well as review current information. Specific methodologies are identified in the respective chapters of this report.

While we identified indications of Medicaid provider and recipient fraud and abuse, we did not pursue such to determine whether fraud or abuse actually occurred. This was outside the scope of this audit and would have required an actual investigation to be performed to make such a determination. We did communicate identified indications of potential Medicaid fraud and/or abuse to DHS.

As part of this audit, we reviewed the status of previous recommendations which were applicable to our audit scope. Two areas

addressed in the State of North Dakota Single Audit for the two-year period ending June 30, 2008 are also included in this report with applicable recommendations being made. These areas relate to the following:

- The knowledge and skills of the administrator of the SURS Unit (recommendation included in Chapter 1); and
- Properly identifying suspected cases of fraud within the Medicaid program (recommendation included in Chapter 2).

We identified two other recommendations from the Single Audit report which do not appear to be implemented. These recommendations address:

- Ensuring adequate information is included in Medicaid provider enrollment files; and
- Conducting a risk analysis of the Medicaid system.

These recommendations are being reviewed as part of the Single Audit work for the period ending June 30, 2010 and no additional recommendations in these areas are addressed in this report.

List of Recommendations

Recommendation 1-1

We recommend the Department of Human Services promote a culture of identifying potential Medicaid fraud and abuse. At a minimum, the Department should:

a) Establish adequate policies and procedures for identifying potential Medicaid fraud and abuse including definitions and steps to take when indications of potential Medicaid fraud and abuse are identified;
b) Clearly define employees' responsibilities of identifying potential Medicaid fraud and abuse;
c) Communicate such responsibilities to employees; and
d) Provide adequate training for identifying potential fraud and abuse to employees.

Recommendation 1-2

We recommend the Department of Human Services comply with federal requirements and ensure an effective surveillance and review process is established to protect the integrity of the Medicaid program.

Recommendation 1-3

We recommend the Department of Human Services ensure the Surveillance and Utilization Review System Unit is sufficiently organized outside the control of the other Medicaid operations so the Unit can objectively perform its functions.

Recommendation 1-4

We recommend the Department of Human Services review staffing of the Surveillance and Utilization Review System Unit and the Fraud and Abuse Unit. At a minimum, the review should:

a) Identify duties/responsibilities of the units' employees which are not a responsibility of the units;
b) Determine whether duties can be reassigned; and
c) Ensure adequate resources exist for fulfilling mandatory responsibilities of the units.

Recommendation 1-5

We recommend the Department of Human Services ensure the administrator of the Surveillance and Utilization Review System Unit has the necessary knowledge and skills to conduct utilization reviews and identify suspected fraud by requiring the administrator to have the necessary qualifications as required by the Medicaid program.

Recommendation 1-6

We recommend the Department of Human Services provide appropriate and convenient methods to report potential Medicaid fraud and abuse. The Department should:

a) Establish a dedicated 1-800 number for reporting fraud and abuse and/or add an option to the current Medical Services Division number dedicated to reporting fraud and abuse; and/or
b) Have an online form which can be submitted electronically.

Recommendation 2-1

We recommend the Department of Human Services submit a new request to the federal government for a Medicaid Fraud Control Unit waiver. Based on the determination from the federal government, the Department should:

a) Take appropriate action to establish a Medicaid Fraud Control Unit in the state of North Dakota; or
b) Ensure adequate resources are made available to efficiently and effectively investigate and refer Medicaid provider fraud and abuse.

Recommendation 2-2

We recommend the Department of Human Services comply with federal requirements and take appropriate action when a provider is suspected of fraud or abuse following a preliminary investigation. When applicable, the Department should:

a) Conduct full investigations; or
b) Refer the case to an appropriate law enforcement agency.

Recommendation 2-3

We recommend the Department of Human Services make improvements with the denied claims information received from the Quality Improvement Organization. At a minimum, the Department should:

a) Effectively monitor and identify patterns of inappropriate billings; and
b) Ensure inappropriate billing information is provided to the Surveillance and Utilization Review System Unit.

Recommendation 2-4

We recommend the Department of Human Services improve the post-payment review process of Medicaid providers to ensure fraud and abuse are effectively identified.

Recommendation 2-5

We recommend the Department of Human Services take appropriate action with ambulance provider claims to ensure Medicaid funds are properly expended. At a minimum, the Department should:

a) Ensure recovery of inappropriately paid claims;
b) Perform an analytical review of ambulance provider claims; and
c) Conduct necessary investigations of suspected provider fraud or abuse.

Recommendation 2-6

We recommend the Department of Human Services make improvements with the audits/reviews conducted on Qualified Service Providers. At a minimum, the Department should:

a) Conduct analytical reviews of data to identify areas to audit/review;
b) Ensure adequate resources exist to conduct audits/reviews of Qualified Service Providers; and
c) Forward indications of Medicaid fraud and abuse to the Surveillance and Utilization Review System Unit, as applicable.

Recommendation 2-7 We recommend the Department of Human Services establish policies and procedures for conducting investigations of potential Medicaid provider fraud and/or abuse.

Recommendation 2-8 We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid provider fraud.

Recommendation 2-9 We recommend the Department of Human Services review practices related to sanctions of Medicaid providers and make appropriate changes to use such options when applicable. At a minimum, the Department should:

a) Review and update North Dakota Administrative Code Chapter 75-02-05 and ensure rules are consistent with the Code of Federal Regulations requirements; and
b) Ensure civil penalties and other sanctions are imposed, as applicable, following investigations of providers which identify inappropriate billings, fraud, and/or abuse.

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a) Refer the case to an appropriate law enforcement agency if there is reason to believe a recipient has defrauded the Medicaid program; and
b) Conduct a full investigation of abuse if there is reason to believe a recipient has abused the Medicaid program.

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Recommendation 3-4 We recommend the Department of Human Services establish policies and procedures for referring suspected Medicaid recipient fraud.

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