PerformCARE®	Policy and Procedure
Name of Policy:	Reporting Suspected Provider Fraud, Waste and Abuse
Policy Number:	CC-001
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Program Integrity
Related Stakeholder(s):	PerformCare Compliance, Claims, Credentialing Committee, Provider Relations
Applies to:	Associates
Original Effective Date:	10/01/01
Last Revision Date:	10/14/24
Last Review Date:	10/30/24
OMHSAS Approval Date:	N/A
Next Review Date:	10/01/25

Policy: PerformCare seeks to ensure the integrity of the HealthChoices program by investigating any reported or alleged fraud, waste, or abuse by a network Provider. The Program Integrity Department Special Investigations Unit (SIU) is charged with preventing, detecting, investigating and reporting fraud, waste and abuse (FWA) for PerformCare. The SIU is responsible for the preventing, detecting, correcting, investigating, and reporting fraud, waste and abuse within the HealthChoices Behavioral Health program across the PerformCare provider network (e.g., provider fraud).

Purpose: To ensure that PerformCare is in compliance with Appendix F of the Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program, Program Standards and Requirements.

Definitions: **Abuse:** Any actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse can be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Abuse is defined in §42 CFR Part 455.2 as 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 costs to the Medicaid program.

Bureau of Program Integrity (BPI): The Commonwealth of Pennsylvania Office of Medical Assistance Programs Bureau that ensures Medical Assistance (MA) Program is protected from provider fraud, abuse and waste, and that MA recipients receive quality medical services.

Center for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

Clinical Investigator: An employee position responsible for reviewing referrals, gathering information related to the allegations, conducting clinical reviews and claims audits and evaluation of findings to determine if evidence indicates billing errors, over-utilization, abusive activity, or a strong suspicion of fraud or abuse. Contributes to the interpretation and trend identification in documentation and claims submission for potential referrals to the SIU through assigned case investigation.

Department of Human Services (DHS): The single state agency with responsibility of the implementation and administration of the Medial Assistance Program (Medicaid or MA).

Explanation of Benefits (EOB): A statement sent by a health insurance company to covered individual explaining what medical treatments and/or servicers were paid for on their behalf.

Fraud: Any deliberate action which results in illegally obtaining payment or something of value for services, or illegally obtaining medical services. It may be an intentional deception, misrepresentation, or concealment of material facts by a provider or recipient with the knowledge that the deception could result in some unauthorized benefit, gain, or unjust advantage to him or herself or some other person.

Fraud is defined in §42 CFR Part 455.2 as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): An Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

Medicaid Fraud Control Unit (MFCU): The section or unit of the Office of the Attorney General responsible for the investigation and prosecution of Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities.

National Correct Coding Initiative (NCCI): A Center for Medicare & Medicaid Services program designed to prevent the improper payment of procedures that should not be submitted together.

Oversight Agencies: Department of Human Services, Bureau of Program Integrity; the Office of the Attorney General's Medicaid Fraud Control Section; the Pennsylvania State Inspector General; Center for Medicare and Medicaid Services Office of Inspector General, and the United States Justice Department.
PerformCare Compliance Director: PerformCare Compliance Director serves as the Compliance Officer for PerformCare and is responsible for internal and external fraud, waste, and abuse monitoring and training. The Director ensures systematically that contract obligations are monitored and met; serves as the privacy officer to ensure corporate structure adheres to HIPAA; and spearheads the employee code of conduct implementation.
PerformCare Executive Director: The Executive Director is to be kept apprised of the SIU investigations and monitor sensitive cases to provide updates to the County Oversights and meet with Providers as necessary.
Special Investigation Unit (SIU): The AmeriHealth Caritas Family of Companies/PerformCare unit responsible for preventing, detecting, correcting, and reporting fraud, waste, and abuse across various categories of health care (e.g. provider fraud, Member fraud, or external fraud).
SIU Fraud Waste and Abuse (FWA) Coordinator: An employee position dedicated to preventing, detecting, investigating, and referring suspected Fraud, Waste and Abuse in the HealthChoices Behavioral Health program to Department of Human Services, responsible for generating and drafting internal and external standard and ad-hoc reports and the triage of incoming referrals.
Third Party Liability (TPL): Any individual, entity (e.g., insurance company), or program (e.g., Medicare) that may be liable for all or part of a Member's health care expenses.
Waste: The thoughtless, careless or otherwise improper use of services by Members, provision of and billing for such services by providers, or payment for the services by payers. Waste includes erroneous claims adjudication by the Company. Waste, as defined by CMS for Medicare Part D, means overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

Acronyms: None

Procedure:

1. PerformCare Identification of Fraud, Waste, or Abuse

1.1. All PerformCare associates are trained upon hire and annually to monitor and report suspected incidents of internal or external fraud, waste, and abuse.

1.1.1. The PerformCare staff identifying the suspected violation will notify their supervisor or any member of PerformCare Executive Management and report the potential fraud, waste or abuse, to the Special Investigations Unit (SIU) in one of the following ways:

a) Phone, call the Fraud Tip hotline at (866) 833-9718
b) Send email to FraudTip@amerihealthcaritas.com

c) Mail, Corporate and Financial Investigations, 200 Stevens Drive, Philadelphia, PA 19113
d) Submit a Fraud Tip Form which can be found on iNSIGHT
e) Fax at (215) 937-8731
f) Speak with a member of the PerformCare Special Investigations Unit
g) Reports can be made anonymously

1.1.2. If an allegation is externally reported by phone, the PerformCare associate receiving the report of fraud, waste, or abuse will:
a) Transfer the individual to the SIU Department; or
b) Forward a voice message to the SIU Department; or
c) Contact a member of the SIU Department and communicate all the information received from the external phone call.

2. General Procedures

2.1. The SIU FWA Coordinator or designee will report suspected fraud, waste and abuse within 30 business days of the date of discovery to the DHS Bureau of Program Integrity's Managed Care Unit.

2.2. Member fraud, waste and abuse

2.2.1. Includes behaviors defined within other protective services reporting requirements, e.g., physical/sexual/verbal abuse, to a PerformCare Member, or discrimination by a Provider against a HealthChoices Member.

2.2.2. The reporting of Member physical/sexual/verbal abuse by a Provider to the DHS BPI Managed Care Unit is the responsibility of the PerformCare Quality Improvement Department.

2.2.3. Any referrals received by the PerformCare SIU regarding Member fraud, waste or abuse, will be forwarded to the QI Department.

2.3. Provider fraud, waste and abuse

2.3.1. The SIU FWA Coordinator or designee shall ensure that PerformCare complies with applicable federal regulatory requirements and DHS mandatory or statutory regulatory requirements with respect to FWA.

2.3.2. PerformCare will ensure County Oversight notification through a report of HealthChoices Contractor Provider investigations. This report is sent to each respective oversight entity on a monthly or quarterly basis in accordance with regional specifications.

2.3.3. PerformCare expects providers to periodically review their records for possible regulatory violations or overpayments and submit a referral of findings via the methods listed in 1.1.1.
a) As an incentive to Medical Assistance (MA) providers, DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith.
b) The Department of Human Services provides a list of examples of inappropriate payment situations suitable for

self-audits, and methods to conduct self-audits and return overpayments, at the DHS web site: https://www.pa.gov/en/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.html

3. SIU Investigation of Fraud, Waste, or Abuse

3.1. The SIU will review the incident to determine if there is an immediate safety concern.

3.1.1. If there is an immediate safety concern, the SIU will immediately notify the PerformCare Quality Improvement Department for further follow up.

3.1.2. If there is not an immediate safety concern, the incident shall be logged and subsequently tracked by the SIU using the case tracking online database.

3.2. Based on their assessment of the information, the SIU determines whether additional information is needed from the referral source and whether or not the case meets fraud, waste, or abuse criteria and requires further investigation. If there is a preliminary allegation of fraud, a referral is made to the BPI and MFCU within 30 days as an Informational Referral. If additional information is found during the SIU investigation, a follow up to the referral is made to the BPI and MFCU. The reason for an audit will not be reported to the provider, as per the direction from MFCU. The following can be part of an SIU investigation which could lead to a referral or report to the BPI:

3.2.1. If the outcome of the record review shows evidence of potential fraud, waste, or abuse, such as an identified overpayment for the violation of established regulations, Medical Assistance Bulletins, PerformCare P&P/Provider Alerts, PerformCare Provider Handbook, etc., the incident will be reported to the BPI and the MFCU.

3.2.2. If during the review of complaints or reports from former or current employees of a provider or referral source allege knowledge of intentional misconduct with the purpose of obtaining payment for which the provider/individual is not entitled, the SIU will report the incident to the BPI and the MFCU.

3.2.3. If the SIU expands a routine audit, (i.e., those audits that were not triggered by a complaint or suspicion of improper conduct) and subsequent findings meet the FWA criteria, such as an identified overpayment as listed in 3.4.1, the SIU will report the findings to the BPI and the MFCU.

3.2.4. In cases of alleged billing/record keeping issues, suspected provider fraud, waste, or abuse and/or employee/subcontractor theft or embezzlement, the SIU will conduct the investigation with oversight by the SIU FWA Coordinator or designee. The findings will be referred to the BPI and the MFCU.

3.3. The SIU, after review by the SIU FWA Coordinator or designee, will document all investigations and case actions on investigations in the SIU database and maintain records of all reports of providers. The investigation information will be shared only on a need- to-know basis with PerformCare as per direction from MFCU.

3.4. When the SIU conducts an external investigation, the process will be as follows:

3.4.1. The SIU will review the referral and contact the person making the allegation in order to obtain additional information, if needed.

3.4.2. The SIU will send a letter to the provider requesting medical records for the level of care under review, staff caseloads, and further information pertaining to a self-report by a provider or other provider documentation. The SIU will not contact the provider if all the information for the referral is provided from PerformCare or other referral sources to the SIU.

3.4.3. The SIU, including the SIU FWA Coordinator or designee, will determine if it is necessary to send an audit team from the SIU to the provider site to further investigate the allegations of the referral and/or obtain medical records.

3.5. The SIU may request that the provider submit a self-report of their internal review of medical records and related documentation if the referral to the SIU indicates that the provider reported the allegation to a PerformCare associate.

3.6. The SIU, PerformCare, and the County Oversight should not disclose the allegation to the provider if intentional criminal conduct is suspected, as the case has the potential to be referred to the MFCU.

3.7. If potential fraud is suspected, the SIU will refer the case to the MFCU. If potential fraud, waste, or abuse is suspected, the SIU will refer the case to the BPI and the MFCU using the MCO Referral Form and instructions to submit referrals to BPI found on the HealthChoices website: https://www.humanservices.state.pa.us/hc-extranet/forms/form_mcoreferral_mc.asp

4. After investigations are completed

4.1. The SIU will prepare a Final Investigative Report of all findings, including a recommendation to address the allegation.

4.2. The SIU member assigned will review the report with the SIU FWA Coordinator, or designee, for approval prior to the report being finalized.

4.3. When the SIU has been able to substantiate an allegation as potential fraud, waste, or abuse, and the violation of established regulations, Medical Assistance Bulletins, PerformCare P&P, Provider Alerts, the provider Handbook, etc. is found to be a pervasive issue in multiple medical records or documentation reviewed or if the findings for the provider in prior cases of the same level of care have found the same pervasive violations, the provider may be required to submit a Quality Improvement Plan (QIP).

4.3.1. The SIU FWA Coordinator or designee and SIU member assigned will review and approve the QIP, assuring that it includes methods of monitoring progress, meets specified timelines for compliance, and permanently corrects any and all improper conduct.

4.3.2. The QIP will be based on applicable laws and regulations governing the report of fraud, waste, and abuse in Pennsylvania MA programs. QIPs are monitored by the PerformCare Quality Improvement Department, as per *QI-SIU-001 Development and Monitoring of Quality Improvement Plans Issued by the Special Investigations Unit*.

4.4. Notwithstanding any corrective action by other oversight agencies, PerformCare may also take disciplinary action against the provider that may include recoupment of improper payment, reporting of findings to the PerformCare Credentialing Committee; and/or suspension or termination from the provider network.

5. Cost Avoidance

5.1. The PerformCare Claims Department utilizes National Correct Coding Initiative (NCCI) edits, per CMS, within the claim processing system to prevent improper payment when incorrect code combinations are billed. Additional cost avoidance activities include denying Third Party Liability (TPL) claims billed when the primary insurance was not billed first, and claims billed that are missing the Explanation of Benefits (EOB).

6. FWA Activities and Oversight Agencies

6.1. The SIU will send all provider self-disclosed criminal conviction to the MFCU and the BPI within thirty (30) days of discovery or notification.

6.2. The SIU will notify BPI of all providers suspected of leaving the network due to a fraud, waste, or abuse investigation via the BPI MCO quarterly report.

6.3. The PerformCare Quality Improvement/Credentialing Department, in accordance with Credentialing Policies and Procedures, will notify BPI and OMHSAS when they refuse to credential or re-credential a provider or primary contractor due to fraud, integrity, or quality.

6.4. The SIU may be contacted by the BPI if they determine the provider is already under review by the BPI or the MFCU. If the BPI or the MFCU review activities are in process, they may ask that the PerformCare SIU suspend or halt review activities or coordinate activities with the relevant agency. The BPI is also available to offer direction or technical assistance in planning the review. The SIU will cooperate with all involved federal, state and county agencies pertaining to a particular investigation.

6.5. PerformCare will notify the BPI either directly or through the primary contractor when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid or Title XX when

making application to be credentialed as a BH-MCO network provider or upon renewal of their credentialing. The Primary Contractor or its BH-MCO shall also notify the BPI of an associated adverse action, such as convictions, exclusions, revocations, and suspensions, taken on provider applications, including denial of initial enrollment due to fraud, integrity issues or quality.

6.6. Once the SIU reports a provider to an oversight agency for potential fraud, waste, or abuse, any complaint or grievance received from the provider must be directed to the applicable agency, per contractual obligations of the HealthChoices program.

7. Recipient Verification Process

7.1. Recipient Verification Process: Each quarter, as directed by the PerformCare Compliance Officer, claims are randomly selected to be verified through letters sent to MA recipients. The letters are sent at the beginning of each quarter and the recipients are directed to contact the SIU if they feel the services listed were billed in error. The recipient verifications completed each quarter are reported on the MCO Quarterly Report due to BPI by the 15th of the month after the quarter ends.

Related Policies:

CC-002 Fraud, Waste and Abuse Program
CC-003 Provider Audits Conducted by the Special Investigations Unit
CC-004 Reporting Suspected Recipient Fraud, Waste and Abuse
PR-003 Ongoing Monitoring of Quality, Sanctions & Complaints
QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers
QI-CR-005 Credentialing Committee
QI-SIU-001 Development and Monitoring of Quality Improvement Plans Issued by the Special Investigations Unit

Related Reports:

None

Source Documents and References:

Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program, Program Standards and Requirements
Child Protective Services Law, 55 Pa. Code § 3490.11. Reporting suspected child abuse
Older Adults Protective Services Act, P.L.1125, No.169
MA Bulletin 99-11-05 Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs
Title 42 – Public Health §42 CFR Part 455.2

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 MCO Fraud, Waste and Abuse Reporting Requirements*
Attachment 2 BPI MCO Instructions and Referral Form
Attachment 3 BPI MCO Referral Supporting Documentation Checklist

Approved by:

Primary Stakeholder

PerformCARE®

CC-001 Attachment 1

MCO FRAUD, WASTE AND ABUSE REPORTING REQUIREMENTS

Reporting requirements are adapted from 55 PA Code §1101, General Provisions for the Medical Assistance Program, specifically 55 PA Code §1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act) and Federal Regulations 42 C.F.R. §438.608(a)(7-8) and 455.23(a).The basis for Recipient referrals is 55 PA Code §1101.91 and §1101.92, Recipient Misutilization and Abuse and Recipient Prohibited Acts.

1. Examples of Suspected Fraud, Waste and Abuse: The following are examples of suspected fraud, waste and abuse that must be reported. Reference the requirements cited above and the specific regulations relating to each provider type for further guidance.

Billing / Record Keeping Issues
Falsifying/altering claims/ encounters/records
Up coding / Incorrect coding
Double billing / Unbundling
Billing for services/ supplies not rendered
Failing to maintain appropriate records
Any issue that could result in collection of overpayment

Suspected Member Fraud / Abuse
Prescription alteration or forgery
Inappropriate use of member's card
Duplication of medications/services
Frequent ER visits; physician, pharmacy, or hospital "shopping"

Abuse of a Member
Physical, mental, and sexual abuse
Discrimination
Neglect
Exploitation

Employee / Subcontractor Theft or Embezzlement

2. Reporting Suspected Provider/Caregiver Fraud, Waste, and Abuse: All Potential Fraud, Abuse, Waste or quality referrals must be made promptly, within thirty (30) days of the identification of the problem/issue, using the online MCO Referral Form, located here - https://www.dpwds.state.pa.us/docushare/dsweb/Login. The MCO or primary contractor must conduct a preliminary investigation to the level of an indication of indicia of fraud. All relevant documentation collected to support the referral must be submitted to BPI electronically using a DocuShare folder designated by BPI. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals." The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is sent with each referral. A copy of the completed checklist, a copy of the referral submission confirmation page, and all supporting documentation for each

referral must be submitted to the designated DocuShare folder. Any egregious situation or act (e.g., those that are causing or imminently threaten to cause harm to a member or significant financial loss to the Department or its agent) must be referred immediately to the Department's Bureau of Program Integrity for further investigation. Potential fraud allegations will result in an automatic dual referral to the Office of Attorney General and the Department. The same information that is submitted to BPI must be uploaded to the Office of Attorney General, Medicaid Fraud Control Section ShareFile system.

3. Reporting Suspected Member (Not Caregiver) Fraud, Waste, and Abuse: All suspected member fraud, abuse and/or waste should be reported directly to the Bureau of Program Integrity's Recipient Restriction Section by the MCO's Recipient Restriction Coordinator using the established restriction referral process.

In the event member fraud is suspected but the criteria for restriction is not met, the MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department's Recipient Restriction Section.

All subsequent information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
P.O. Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

Pennsylvania HealthChoices
Extranet

MCO Referral Form - Instructions for MCOs
(MCO Referral Form)

This procedure is to be used when:

- A Managed Care Organization (MCO) is required to report to the Department any act by Providers/Enrollees/employees that may affect the integrity of the HealthChoices program.
- An MCO suspects that either potential fraud and/or abuse may have occurred, the MCO shall report the issue to the Bureau of Program Integrity (BPI) and provide an account of the activity by the MCO fraud and abuse staff.
- An egregious situation (a situation that is causing, or may cause, harm to a member, including abuse and/or neglect, or significant financial loss to the MCO or Department) has occurred.

*Please keep in mind the confidentiality requirements as part of 42 CFR “Part 2”-Confidentiality of substance use disorder patient records prohibits disclosure of patient identifying information.

Purpose

This document is to provide an accurate accounting of the potential fraud and abuse issues identified by the MCO fraud and abuse staff.

Discussion

The MCO is required to refer any potential fraud and abuse issues. In accordance with the HealthChoices Agreement Section V(O)(4)(f) and Exhibit KK, the MCO is mandated to report the following: (1) any act by Providers/Enrollees/Employees that may affect the integrity of the HealthChoices program (2) quality issues that may affect the MA consumer's health and (3) any egregious situation (a situation that is causing, or may cause, harm to a member, or significant financial loss to the MCO or Department). If the MCO fails to provide referrals, the MCO may be subject to penalties/sanctions. HealthChoices Behavioral Health Program Standards and Requirements, Primary Contractor Part II – 5(D)(6) and Appendix F also require reporting of any suspected or substantiated fraud or abuse and clarifies that this includes Billing / Record Keeping Issues, Suspected Member Fraud / Abuse, Abuse of a Member, and Employee / Subcontractor Theft or Embezzlement.

The following are general instructions for completing the referral form required to be submitted by the MCOs to DPW. The referrals should contain information on the HealthChoices Program only unless otherwise noted.

The MCO will submit these referrals in the format specified by DHS.

Procedure

MCO Responsibility:

The MCO must submit a "MCO Referral Form" to document the Providers/Enrollees/Employees suspected of potential fraud and abuse. The form instructions will outline the appropriate referral procedure. To access the "MCO Referral Form", click the "MCO Referral Form" link at the top of this page. All fields marked with an asterisk must be completed.

The MCO must submit a "Checklist of Supporting Documentation for Referrals" form with each referral. Please check the appropriate boxes on the checklist that indicate the supporting documentation included with your referral. This checklist is meant to be a guide so that MCOs have a sample of what information should be included with each type of referral.

BPI Responsibility:

BPI reviews all MCO referrals received. BPI will gather background information regarding the referral. BPI will check licensing, eligibility, history, and for any active criminal/civil cases regarding the subject of the referral. When “Potential Fraud” is selected as the Referral Type, the Medicaid Fraud Control Section (MFCS) will receive a copy of the referral electronically when the referral form is submitted to BPI. BPI compares submitted referrals to the quarterly reports to ensure the quarterly reports accurately reflect the fraud and abuse referrals that were made for each quarter. BPI tracks referrals for trending purposes.

MCO Referral Form Instructions

Listed below are instructions for completing each field. All fields marked with an asterisk **must** be completed or the form will not be transmitted. Some fields are edited and will only allow you to select an item from the drop-down boxes.

- **MCO** - Select the appropriate organization from the drop-down box.
- **MCO Tracking Number** - Provide the unique MCO Tracking Number if known to serve as a cross reference for identification.
- **Date** - The date will automatically populate when you begin to complete the MCORF.

- **Referral Type** - Select the appropriate type of referral from the drop-down box. Potential Recipient Restrictions are not to be reported on this form.
- **Participant Type** - Select the appropriate participant type from the drop-down box.
- **Participant Name** - This is the provider/staff/entity/facility name that is being referred, and if applicable, it will be the name that is linked to the Provider ID Number line. Ensure the name is listed correctly. **For the following: mobile therapist, therapeutic staff support (TSS), behavioral health coordinator (BHC), etc., provide that individual's name on this line. In parenthesis, list the entity that employs the individual and the entity's PROMISe™ ID.** The individual's identification number, if applicable, should also be listed.
- **National Provider Identifier (NPI) Number** - This is the 10-digit national identifier for covered health care providers.
- **Provider ID Number** - This is the 9-digit PROMISe™ (Master Provider Index - MPI) number (if referred entity has a Provider ID Number). **For the following: mobile therapist, therapeutic staff support (TSS), behavioral health coordinator (BHC), etc., provide the PROMISe™ ID Number of the entity that employs the individual.**
- **Provider Service Location Number** - This is the 4-digit service location number from the PROMISe™ system that corresponds with the Service Location Address listed.
- **Service Location Address** - This is the address where the services were provided or where the incident occurred. If the services were provided in the community, or the incident occurred in the community, away from the physical office, this will be the appropriate corresponding service location address the recipient is linked to for these specific services.
- **Involves an MA Recipient?** - Select Yes or No
- **Recipient(s) Name** - This is the name of the recipient(s) who is involved in the issue addressed in the referral. If multiple recipients are to be named, one recipient should be listed in this field and the others should be listed in the “Potential Witness/Contact Information” block.
- **Recipient(s) ID Number (RID)** - This is the PROMISe recipient identification number that corresponds with the recipient named on the referral.
- **Recipient Address** - This is the recipient's address.
- **Recipient Phone Number** - This is the recipient's phone number.
- **County Where Incident Occurred** - Select the appropriate county from the drop-down box.
- **Provider Phone Number** - This is the phone number of the provider listed.
- **Provider License Number** - This is the license number. **For the following: mobile therapist, therapeutic staff support (TSS), behavioral health consultant (BHC), etc., provide the license number of the entity that employs the individual.** If the referred entity does not have a license number, enter 0s.
- **DEA Number** - This is the provider's Drug Enforcement Administration number.
- **Provider Type** - From the drop-down box, select the numerical provider type that correlates to the services provided by the individual/entity on the "Provider Name" line.
- **Provider Specialty** - From the dropdown box, select the numerical provider specialty which corresponds to the services/incidents on this referral form.
- **Dates of Service/Dates of Incident** - This is the date(s) of service or date(s) of incidents that are covered by the referral. If the Date of Service/Incident is unknown, use Date of Referral. If only one day is involved, use the same date for both the From and the To Dates.
- **Method by which the MCO became aware of this issue** - This is the method by which the MCO became aware of the issue addressed in the referral.
- **Potential Witness/Contact Information** - This will include the names, titles, addresses, and phone numbers of any potential witnesses and contacts regarding the referral. If multiple recipients are to be named, one recipient should be listed in the "Recipient(s) Name" field and the others should then be listed in this "Potential Witness/Contact Information" block.
- **Estimated Amount of Money Involved** - This is the amount of dollars that the MCO has identified, and that the provider/entity/recipient will return. This is the expected amount of recoupment.
- **Did the MCO recover any amount?** - Enter Yes or No
  If yes, enter amount recovered.
  Does the MCO plan to proceed with additional recoveries? Yes No
  If no, enter yes or no to the question - Does the MCO plan to proceed with recovery?
- **Describe the potential issue under review** - Be specific and describe in detail the issue under review. Cite the procedure codes and descriptions, violation of regulations, etc. involved.
- **Claims were Reviewed** - Select Yes if any claims were reviewed in investigating this referral. If claims were reviewed, then indicate the date range for which the claims were reviewed. Also, indicate how many claims were reviewed and what findings resulted from the claims review.
- **Medical Records were Reviewed** - Select Yes if medical records were reviewed. If records were reviewed, then indicate the date range for which the records were reviewed. Indicate what specific parts of the record(s) were reviewed, or if the complete record(s) were reviewed. Also, indicate how many records were reviewed and what findings resulted from the records review.

- **Are medical records being submitted to BPI?** - Select Yes or No
- **Provider was Interviewed** - Select Yes if the provider was interviewed. If the provider was interviewed, indicate the findings.
- **Provider Staff was Interviewed** - Select Yes if any of the provider staff was interviewed. If any of the provider staff were interviewed, indicate the findings.
- **Recipient(s) Interviewed** - Select Yes if any recipients were interviewed. If any recipients were interviewed, indicate the findings.
- **Other Relevant Information** - Select Yes if there is any additional information pertaining to this referral. Describe and indicate the findings.
- **Select the check box to indicate that all supporting documentation has been uploaded to the appropriate MCO folder in DocuShare.**
- **Submitted By** - enter the name of the person submitting the referral in the text box

Form Submission

When the form is complete and ready to be sent, click on the "Submit" button. An information window will appear either instructing you to enter or select information which was omitted from required fields, or it will ask you if you are sure you want to submit the form. The form will be sent directly to the Bureau of Program Integrity (BPI).

Please note: If “Potential Fraud” is selected as the Referral Type, the Medicaid Fraud Control Section (MFCS) will receive a copy of the referral electronically when the referral form is submitted to BPI.

Confirmation Notice

Once your referral has been successfully submitted to BPI you will receive a confirmation notice. This notice will automatically populate with all of the information which was entered on the MCORF.

Print the confirmation notice and attach to the checklist and supporting documentation being sent to BPI through DocuShare. You may want to print a copy of the confirmation notice for your own records.

If you have any questions on what issues need to be referred, feel free to call the MCO unit at BPI.

Pennsylvania HealthChoices
Extranet

Bureau of Program Integrity

MCO Referral Form

Please review the form instructions prior to each use as they may have changed. Form Instructions

*MCO : Select From List

MCO Tracking Number :

Date of Referral : 10/17/2024

*Referral Type : Select From List

*Participant Type : Select From List
Potential Recipient Restrictions are not to be reported on this form.

*Participant Name :

National Provider Identifier (NPI) Number : Format: 9999999999

Provider ID Number : - Format: 999999999 - 9999
(MPI - Service Location)

*Service Location Address :

*City, St, Zip : , , -

*Does this involve a MA recipient? ○ Yes ○ No

*County Where Incident Occurred : Select From List

*Provider Phone Number : Format: 888-888-8888

*Provider License Number :

DEA Number :

*Provider Type : Select From List

*Provider Specialty :

*Date(s) of Service/Date(s) of Incident :

From Date : Format: MM/DD/YYYY

To Date : Format: MM/DD/YYYY

*Method by which the MCO became aware of this issue :
(Ex: Hotline, Data Mining, etc)

*Potential Witness/Contact Information (Names, Titles, Addresses, Phone Numbers) :

*Estimated Amount of Money Involved : $ Format: 0.00

*Did the MCO recover any amount? : ○ Yes ○ No

*Describe the issue under review, citing the procedure/diagnosis codes and descriptions, violation(s) of Regulations, etc. :

Check all appropriate boxes below and give detailed answers to the corresponding questions.

*Were claims reviewed? ○ Yes ○ No

Date(s)/Date Range Reviewed:

Number Reviewed:

Describe in as much detail as possible what findings resulted from the claims review:

*Were medical records reviewed? ○ Yes ○ No

Date Range Reviewed:

Number Reviewed:

*Are medical records being submitted to BPI? ○ Yes ○ No

*Was the provider interviewed? ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

*Were the provider's staff interviewed? ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

*Were recipients interviewed? ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

*Is there any other relevant Information or case outcome? ○ Yes ○ No

Describe and indicate findings:

☐ * In accordance with the HealthChoices Agreement, all supporting documentation as required on the Checklist of Supporting Documentation for Referrals, including relevant claims, medical records, and other supporting documentation has been downloaded to the appropriate MCO folder on DocuShare. All incomplete referrals will be rejected and considered in breach/violation of the requirements listed in the HealthChoices Agreement and noted on the MCO Quarterly Compliance Report.

*Submitted By :

* *Required Fields*

Submit Clear Form

PerformCARE®

CC-001 Attachment 3

MCO _____
MCO Tracking #_____
Date Referred_____

Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for provider or staff person referrals-

- ☐ Confirmation page from online referral
- ☐ Encounter forms (lacking signatures or forged signatures)
- ☐ Timesheets
- ☐ Attendance records of recipient
- ☐ Written statement from parent, provider, school officials or client that services were not rendered or a forged signature
- ☐ Progress notes
- ☐ Internal audit report
- ☐ Interview findings
- ☐ Sign-in log sheet
- ☐ Complete medical records
- ☐ Resume and supporting resume documentation (college transcripts, copy of degree)
- ☐ Credentialing file (DEA license, CME, medical license, board certification)
- ☐ Copies of complaints filed by members
- ☐ Admission of guilty statement
- ☐ Other:_____

Example of materials for pharmacy referrals-

- ☐ Paid claims
- ☐ Prescriptions
- ☐ Signature logs
- ☐ Encounter forms
- ☐ Purchase invoices
- ☐ EOB's
- ☐ Delivery slips
- ☐ Licensing information
- ☐ Other: _____

Example of materials for RTF referrals-

- ☐ Complete medical records
- ☐ Discharge summary
- ☐ Progress notes from providers, nurses, and other staff
- ☐ Psychological evaluation
- ☐ Other: _____

Example of materials for behavioral health referrals-

- ☐ Complete medical and mental health record
- ☐ Results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ Summaries of all hospitalizations
- ☐ All psychiatric examinations
- ☐ All psychological evaluations
- ☐ Treatment plans
- ☐ All prior authorizations request packets and the resultant prior authorization number
- ☐ Encounter forms (lacking signatures or forged signatures)
- ☐ Plan of care summaries
- ☐ Documentation of treatment team or Interagency Service Planning Team meetings
- ☐ Progress notes
- ☐ Other: _____

Example of materials for DME referrals-

- ☐ Orders, prescriptions, and/or certificates of medical necessity (CMN0 for the equipment
- ☐ Delivery slips and/or proof of delivery of equipment
- ☐ Copies of checks or proof of copay payment by recipient
- ☐ Diagnostic testing in the records
- ☐ Copy of company's current licensure
- ☐ Copy of the Policy and Procedure manual applicable to MDE items
- ☐ Other: _____