

Medicaid Program Integrity

Protecting Idaho's Investment in Health Care



Presented by Medicaid Program Integrity Unit
May 2017

Bureau of Audits and Investigations

Investigative Units

- Welfare Fraud Unit
 - Client Eligibility (food stamps, cash assistance)
 - Idaho Child Care Providers (ICCP)
- Medicaid Program Integrity (MPI) Unit
 - Medicaid Providers

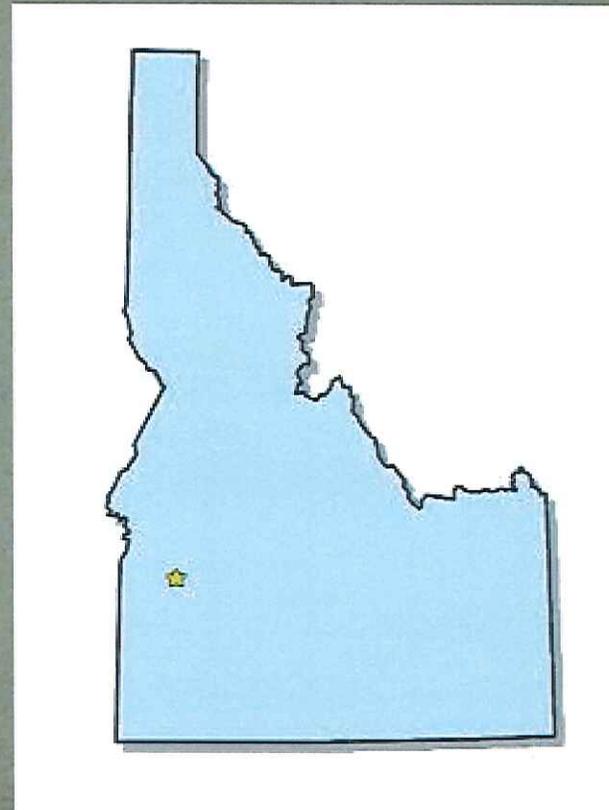
Other Investigative Units

- State Licensing Boards/Bureaus
- Department of Insurance
- Attorney General's Medicaid Fraud Control Unit (MFCU)
- Department of Health and Human Services - Office of Inspector General (OIG)
- Federal Bureau of Investigation (FBI)
- Local Law Enforcement
- Drug Enforcement Administration (DEA)

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Medicaid Program Integrity Unit (MPI Unit)

- Locations
 - CDA – 2 analysts
 - Boise – 9 analysts
 - Blackfoot – 5 analysts



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MPI Unit - Primary Responsibilities

- Conduct Preliminary Investigations
 - Complaints/Referrals/Pro-active
 - Refer credible allegations of fraud to the Medicaid Fraud Control Unit (MFCU)
- Identify Medicaid Overutilization of Services
 - Providers
 - Clients
- Recover overpayments and assess civil monetary penalties
- Make Program/System Recommendations

MPI Unit Audit Process

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Case Origin

- Complaints
 - Provider Employees
 - Medicaid Clients
 - Other Providers/Agencies
 - Ex-spouses/Significant others
- Referrals
 - Medicaid
 - Licensing & Certification
 - Medicaid Fraud Control Unit (MFCU)
 - Office of Inspector General (OIG)
 - State Licensing Boards
- Pro-active
 - Data Mining
 - Focused Reviews of Services or Programs

Provider Utilization Review

- Peer Grouping
 - Grouping Process:
 - Categorizing providers/specialties
 - Capturing data within the group
 - Comparing utilization
 - Selection Process
 - Identification of greatest outliers
- Review Results
 - No findings – no further review
 - Can't determine reason for outlier – open case

Client Utilization Review

- Outliers
 - High emergency room usage
 - High number of prescribers
 - High number of prescriptions
- Review Results
 - No findings – no further review
 - Provider findings – open case on provider
 - Prescription concerns – refer to Medicaid for possible client lock-in to one pharmacy/one prescriber
 - Overutilization of services – refer to Medicaid for possible care management

Case Activities

- Activities may include one or more of the following:
 - Review of claim history
 - Review of provider records
 - Records request
 - By mail - 20 working days
 - On-site request - immediate access to records
 - Interviews
 - Providers
 - Employees
 - Clients
 - Surveys

Case Resolution

- Allegation unfounded - no action
- Educational letter
- Recoupment of payments
- Assessment of civil monetary penalties
 - Up to \$1,000 per item or service improperly claimed
 - Multiple penalties – not less than 10% of amounts claimed
 - Criminal history background check violations - \$500 per employee without clearance per month up to a maximum of \$5,000 per month

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Case Resolution

- Disputed findings
 - Providers are given the opportunity to dispute findings through written or oral communication and/or face-to-face meetings
 - If necessary, providers may meet with management to discuss findings
 - If provider still disagrees with findings, an administration action notice will be issued and provider can request an administrative hearing

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Case Resolution

- Suspension of payments pending further investigation
- Termination of provider agreement
- Referral for civil action/criminal prosecution
- Exclusion from Medicaid program

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Administrative Appeals

- All administrative actions can be appealed
 - An appeal does not stay the action
- IDAPA 16.05.03.101 – filing of appeals
- At a hearing, providers are given the opportunity to demonstrate to a hearing officer that the Department's action is not supported by the facts or law.

Civil Monetary Penalties (CMP)

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Civil Monetary Penalties

- Civil monetary penalties are administrative penalties assessed for the following conduct:
 - Submission of incorrect claims
 - Submission of fraudulent claims
 - Knowingly making false statements
 - Billing for services/items known to be medically unnecessary
 - Failing to provide immediate access to records
 - Failing repeated or substantially to comply with rules and regulations
 - Knowingly violating provider agreement
 - Failing to repay Medicaid debts
 - Fraudulent or abusive conduct

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Civil Monetary Penalties

- Civil monetary penalties are intended to be remedial, at a minimum recovering costs of investigation and administrative review, and placing the costs associated with non-compliance on the provider.
- Civil monetary penalties are not assessed when a provider self-reports an overpayment and the Department receives the report prior to the initiation of a Department audit.

Civil Monetary Penalty Rule Changes

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Civil Monetary Penalty Rule Changes

- 7/1/16 – temporary rules
- 3/29/17 – final
 - Reduces the minimum penalty from 25% to 10%
 - Provides methodology for determining penalty percentages based on type of conduct
 - Provides methodology for penalty enhancements
 - Provides methodology for assessing penalties for failure to get required criminal history background checks for employees
 - \$500 per employee per month
 - Amount maxes out at \$5,000 per month (10 employees)

Changes to Penalty Percentages

- Conduct resulting in no overpayment
 - Collecting fees from client when not entitled to collect (10%)
- Minor rule violations (10%) – provided services and services were properly paid but violated rule, policy or provider agreement. Examples include:
 - incorrect date spanning
 - Failed to list required provider credentials
 - Failed to obtain required client signatures
- Significant rule violations (15%) – services were provided but violated rule, policy or provider agreement
 - Incomplete physician referrals
 - Failed to maintain documentation once valid Healthy Connections referrals were obtained

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Changes to Penalty Percentages

- Conduct resulting in overpayment
 - Significant rule violations (15%) – services were provided but violated rule, policy or provider agreement. Violations include, but are not limited to:
 - Billing more services than allowed
 - Billing non-physician services as physician services
 - Billing incorrect codes or modifiers
 - Inadequate documentation to support services billed

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Changes to Penalty Percentages

- Conduct resulting in overpayment , cont.
 - Significant rule violations related to client care (20%) – Services were provided but violated rule, policy, or provider agreement related to client care. Violations include, but are not limited to:
 - Failed to obtain required Healthy Connections referrals or failed to list required core elements, such as the start and end dates on the referral
 - No required physician or practitioner signatures
 - No orders or inadequate orders, assessments, plans or evaluations prior to delivery of service or items
 - Services or items provided by unqualified staff
 - Services or items provided by excluded individual
 - Non-covered services

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Changes to Penalty Percentages

- Conduct resulting in overpayment, cont.
 - Significant rule violations (25%) for no service or refusal of immediate access to documentation. Services were not provided, were not documented, or provider refused to provide immediate access to documentation upon written request. Violations include, but are not limited to:
 - Billing and receiving payment multiple times for the same service or item
 - No documentation
 - Cloned documentation
 - Service not provided
 - More units billed than provided
 - Billing laboratory services provided by independent laboratory, unless an exception applies, such as an independent laboratory that can bill for a reference laboratory
 - Missing required pre-authorization

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Enhanced Civil Monetary Penalties

- The Department may enhance the penalties if the error rate percentage is greater than 25% .
 - Additional 5% penalty - when more than 25% of the audited services are in error
 - Additional 10% penalty - when more than 35% of the audited services are in error
- The Department may enhance the penalties an additional 15% when the Department determines the conduct was committed fraudulently or knowingly.

CMPs for Criminal History Background Check Violations

- The Department may assess CMPs for failing to perform required background checks, failing to meet required time lines for completion of background checks, or using staff who disclosed a disqualifying crime on applications.
 - \$500 for each month worked for each staff person or contractor without required background check
 - Maximum amount assessed per month is \$5,000
 - Partial months are considered full months for purposes of determining the amount of the penalty

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Recovering Debts

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Debt Recovery

- Options
 - Provider adjusts claims
 - Provider sends lump sum payment
 - Provider enters into a repayment agreement
 - Typically 12-months or less
 - Medicaid offsets future payments through Molina
 - Combination of above actions

Unpaid Debt Recovery

- Payment offset
- Terminate provider agreement
- Referral to collections agency
- Pursue collection through court

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Exclusions

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Exclusions

- State Exclusions
 - State Medicaid program issues notice
- Federal Exclusions
 - Office of Inspector General (OIG) issues exclusion notice

Exclusions

- Types of Exclusions
 - Mandatory
 - Permissive

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Mandatory Exclusion

- Individual convicted of criminal offense related to the delivery of an item or service under a federal or any state health care program, including performance of management or administrative services relating to the deliver of items or services under any such program.
- Individual convicted of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care system, including any offense the Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program participant.
- Individual is identified as excluded by another state or the OIG or any person CMS directs the Department to exclude.
- Excluded not less than 10 years

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Permissive Exclusion

- Individual has a finding by a governmental agency of endangering the health or safety of a patient, or of patient abuse, neglect or exploitation.
- Individual failed or refused to disclose, make available, or provide immediate access to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained, which the Department deems relevant to determining the appropriateness of payment.
- Other reasons for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity.
- Excluded not less than 1 year.

Effect of an Exclusion

- No payment program may be made for any items or services, including administrative and management services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered, or prescribed by an excluded individual, except as provided in regulations found at 42 CFR 1001.1901(c), during the period the individual is excluded.
- Federal exclusions have national effect and apply to all federal procurement and non-procurement programs and activities.
- Program payment may not be made to any entity in which the excluded individual is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services.

Audits of Providers Employing Excluded Individuals

- School district billed for 6 years of services provided by excluded speech therapist
 - \$82,893.10 overpayment
 - \$10,812.63 civil monetary penalty
- Hospital used an excluded individual to work as a patient financial counselor
 - \$33,168.33 overpayment
 - \$8,292.08 civil monetary penalty
- Hospital used an excluded nurse to provide Medicaid services
 - \$8,279.25 overpayment
 - \$2,069.81 civil monetary penalty

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Reinstatement

- What happens when the exclusion period has expired?
 - The individual is still excluded until reinstated
 - The individual must request reinstatement from the agency that excluded
 - If excluded by both the OIG and Idaho Medicaid, reinstatement requests must be submitted to both agencies
 - Once reinstated, the individual remains on the exclusion list but there will be a reinstatement date listed

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State Exclusion List

Promoting and protecting the health and safety of all Idahoans

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IDAHO Department of Health and Welfare

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You are here: Providers > Medicaid Providers

Medicaid Providers

Information Releases
 Medicaid Newsletter
 Medicaid Fee Schedule
 Provider Enrollment
 Provider Handbook

Medicaid Providers

Idaho Medicaid is a medical insurance program that serves as a safety net for people who have low incomes, have a disability, or are elderly.

Idaho offers four different plans to meet the individual needs of participants:

- **Standard** – Provides only federally mandated benefits. All participants have the option to select this Standard Plan.
- **Basic** – Benefits include preventive as well as medical, dental, and vision services for participants who meet income standards.
- **Enhanced** – Benefits include Basic Plan benefits plus long-term, developmental disability, and mental health services and supports for participants who are eligible due to disabilities or have special health needs.
- **Medicare-Medicaid Coordinated** – For participants who are eligible and enrolled in both Medicare and Medicaid. This plan includes the same benefits identified in the Enhanced Plan but include an option to receive services through a Medicare Advantage Plan of their choice.

Effective June 7, 2010, Idaho Medicaid contracted with **Molina Medicaid Solutions** to be the MHIC claims processing center as well as provide provider training, billing, and operational support for all Medicaid providers.

Magellan Medicaid Administration is providing these services for the pharmacy program.

For more information on the Idaho Medicaid Program visit the **Medicaid home page**.

Molina Medicaid Solutions Resources

HealthPAS Online
 Provider Portal
 Provider Record Update Guides
 Provider Handbook
 Paper Claim Forms & Instructions

Magellan Medicaid Administration Resources

Idaho Medicaid Pharmacy Program
 Pharmacy Claim Submission Specifications
 Pharmacy FAQ and Notifications

Payment Error Rate Measurement

PERM Information Sheet

Provider Exclusion List – Program Integrity

Idaho Medicaid Provider Exclusion List

FAQs

- Telehealth FAQs
- ICD-10 FAQ
- Idaho Behavioral Health Plan
- Electronic Filing and Signature FAQs
- Frequently Asked Questions - Federally Funded Incentive Payments to Primary Care Service Providers

Forms

- EPSDT Request for Additional Services
- Long-Term Care Notification of Change
- Request to Transfer to Enhanced Plan Benefit (M0002)
- Hospital Inpatient - Notification of Birth for Medicaid Eligibility
- Optional Referral Form for Newborn Medicaid Coverage - HW1046
- Idaho Special Rate Request Form -Skilled Nursing Facility
- ICF/ID Special Rate Request Form
- ICF/ID Special Rate Leave of Absence Form

Provider Training and Training Forms

Title

Completion of NEW Level 1 Pre-admission Screening Resident Review WebEx Recording

Frequently Asked Questions

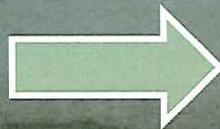
Instructions for Completion of Level 1 Pre-Admission Screening and Resident Review (PASRR) Prescreen 87

Pre-admission Screening Resident - Review PowerPoint

Pre-admission Screening Resident Handouts - Review Handouts

Policies

Chiropractic Policy
 Circumcision Policy
 DME, DMS, and PBO for Participants Residing in an ICF/ID
 Electronic Signature Policy
 Forensic Exams Interviews
 Outpatient Cardiac Rehabilitation Policy
 Podiatry Policy
 Telehealth Policy
 Vision Policy



State Exclusion List

Idaho Medicaid Exclusion List - last updated February 10, 2016

The following providers, individuals and entities were excluded by the Idaho Department of Health and Welfare and are excluded from participation in the Idaho Medicaid program. The Idaho Medicaid Exclusion List does not contain information about exclusion action taken by the Department of Health and Human Services Office of Inspector General (HHS-OIG) or other state agencies. Furthermore, state exclusion periods are often different than federal exclusion periods. Therefore, providers must check both the Idaho Medicaid Exclusion List and the HHS-OIG Exclusion List to determine whether a provider, individual, or entity is excluded and, if so, the dates of such exclusion. Information on Medicaid exclusions by other states can be obtained on other state websites or by contacting states where providers, individuals and entities billed. The HHS-OIG Exclusion List is accessed at <http://exclusions.oig.hhs.gov>.

Federal law prohibits payment for services rendered by state or federally excluded providers, individuals and entities. Moreover, civil monetary penalties may be imposed against any providers who use or contract with excluded providers, individuals or entities to provide items or services to Medicaid participants. Providers are responsible for screening all employees and contractors to identify excluded individuals and are responsible for searching the HHS-OIG website and the Idaho Medicaid Exclusion List monthly to capture exclusions and reinstatements. Providers, individuals and entities are not automatically reinstated at the end of the state or federal exclusion period. If providers, individuals or entities on the state or federal exclusion lists do not have reinstatement dates listed, they are not eligible to provide services.

Please e-mail exclusion verification inquiries to Prvfraud@dhw.idaho.gov.

Name	Exclusion Start Date	Date Eligible for Reinstatement	Date Reinstated	Additional Information
ACHIEVING A BETTER LIFE	1/23/06	1/23/16		Endangerment of health and safety of a patient
ADAMSON, KERMIT 'MIKE' ARTHUR	11/3/06	11/3/16		Convicted of embezzlement

Federal Exclusion List

<http://oig.hhs.gov/fraud/exclusions.asp>

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U.S. Department of Health & Human Services
Office of Inspector General
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Home > Exclusions

Exclusions Program

Online Searchable Database

The Online Searchable Database enables users to enter the name of an individual or entity and determine whether they are currently excluded. If a name match is made, the database can verify the match using a Social Security Number or Employer Identification Number.

[Read More >>](#)

LEIE Downloadable Databases

The Downloadable Data File enables users to download the entire List of Excluded Individuals and Entities to a personal computer.

I'm looking for

Let's start by choosing a topic

Select One

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- [Contact the Exclusions Program](#)

Medicaid Program Integrity Unit Audit Findings

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Fraudulent or Abusive Activities

- Billing for services not provided
 - Transportation provider
 - billed 400 miles per day to transport child to medical appointments that didn't occur
 - billings included 400-mile transports on Thanksgiving and Christmas



Fraudulent or Abusive Activities

- Billing for services not provided
 - Mental health clinic billed mental health treatment when taking children on weekend trips to Yellowstone, National Park, Bear Lake, camping, and Salt Lake City



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Fraudulent or Abusive Activities

- Altering documents
 - Dentist altered records to match what he wanted to bill, not what was actually performed

2/24/00	PM	8	1.8 collid	Sent veneers	Calibry cement	with flow A1	skin bond	(D)
2/1/00	PM	9		Sent veneers	with flow A1	skin bond		



Fraudulent or Abusive Activities

- Billing for non-covered items
 - A self – directed program’s community support worker requested approval to purchase needed items for client
 - Purchased non-covered items with check she received
 - Returned the next day to store and used the same check to purchase more non-covered items

WASTEBAGS	001370083599S	13.47	AD
BATH TISSUE	003600036094S	6.97	AD
PAPER TOWELS	003600011370S	6.97	AD
3AB JUICE	002870011305SF	2.68	AD
SPRITE	004900001938SF	6.98	AD
OFFICE CHAIR	694547610055S	34.84	AD
	SUBTOTAL	71.91	
PRODUCT SERIAL #	%NE3HF004424		
BLURAYPLAYER	088517008717S	78.00	AD
PWRFRM CMPCT	001112011203S	39.96	AD
	SUBTOTAL	189.87	
5FT SCRCROW	070801679897S	6.44	AD
5FT SCRCROW	070801679899S	6.44	AD
5FT SCRCROW	070801679895S	6.44	AD
	SUBTOTAL	209.19	

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Fraudulent or Abusive Activities

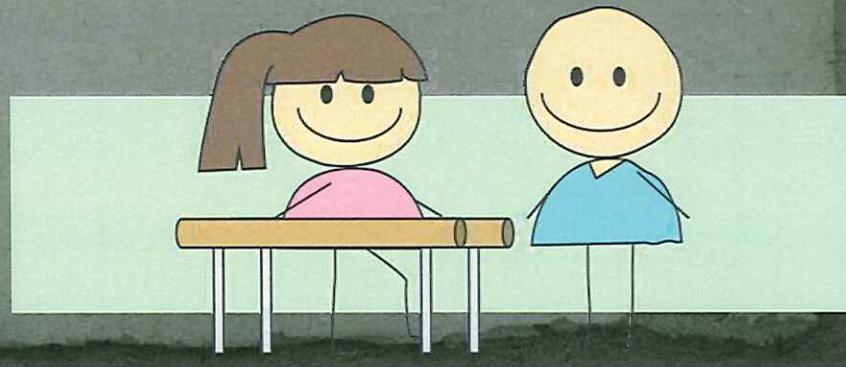
- Misrepresented services
 - DME provider billed power wheelchairs when providing scooters
 - Billed accessories not provided
 - Billed cushions not provided
 - Altered documents to show billed items listed on invoices



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Fraudulent or Abusive Activities

- Unqualified staff
 - Physical therapist billed physical therapy provided by employees with no degrees, credentials or formal training to perform therapy



Fraudulent or Abusive Activities

- Unqualified staff
 - Mental health clinic billed mental health treatment provided by employees with no degrees, credentials or formal training to perform mental health treatment



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Fraudulent or Abusive Activities

- Unqualified staff
 - Mental health clinic used an unqualified Medicaid client to provide group mental health therapy.
 - In addition to billing the Medicaid's time, the clinic billed for the case management of the client while the client was providing the "therapy."

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Fraudulent or Abusive Activities

- Billing non-physician services as physician services

IDAPA 16.03.09.504.01

Misrepresentation of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited.

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Fraudulent or Abusive Activities

- Billing non-covered services as covered services
- Backdating Healthy Connections referrals
- Forging physician signatures authorizing treatment
- Upcoding services
- Failure to maintain required documentation
 - Required to document contemporaneously
- Destroying or changing documents after receiving requests/subpoenas for them
- Deleting/altering records maintained in computer software programs



Fraudulent or Abusive Activities

- Billing for medically unnecessary services
- Billing clients the difference between the billed and the paid amount
- Failure to refund identified overpayments
- Billing for services to deceased clients
- Billing services for Medicaid ineligible clients under eligible Medicaid numbers
- Changing dates of service to coincide with eligibility dates

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Fraudulent or Abusive Activities

- Billing for services by unlicensed providers
- Cloning records
- Services provided by unqualified staff but documented as being provided by qualified staff
- Concealing ownership in a business
- Billing services provided by excluded individuals
- Billing used items as new items
- Billing Medicaid more than customary charge
- Using false credentials

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How to Survive an Audit

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How to Survive an Audit

- Be Prepared
 - Expect auditors will show up tomorrow



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How to Survive an Audit

- Perform Quality Assurance Reviews
 - Monthly/Quarterly/Annually
 - Prior to billing
 - After billing

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How to Survive an Audit

- Quality Assurance Reviews
 - Sample billings
 - Documentation
 - Adherence to program requirements
 - Employee time cards
 - Remittance advice
 - Claim adjustments
 - Document findings

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How to Survive an Audit

- Record Keeping
 - Know what record requirements apply to you
 - 5 year retention
 - Immediate access to records
 - Sufficient to support amount/scope of services billed
 - Document at the time of service

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How to Survive an Audit

- Know program and compliance requirements and changes
- Make sure employees are aware of program and compliance requirements
- Make sure employees aren't on the Idaho or federal exclusion lists

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How to Survive an Audit

- Program and Compliance Requirements
 - Code of Federal Regulations
 - Statutes
 - Administrative Rules
 - Provider Handbook
 - Provider Agreement
 - Information Releases
 - Medicaid Bulletins

How to Survive an Audit

- If You Don't Know, Ask
 - Document telephone responses
 - Request policy clarifications in writing

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Self Reporting Overpayments

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Self Reporting Overpayments

- Providers are required to refund overpayments to the Department within 60 days of identification

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Self Reporting Overpayments

Provider agreement:

5. Accurate Billing.

.....The Provider shall be solely responsible for the accuracy of claims submitted, and shall immediately repay the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed.

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Self Reporting Overpayments

42 USC § 1320a-7k(d)

(1) In general

If a person has received an overpayment, the person shall

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier or contractor to whom the overpayment was returned in writing of the reason for the overpayment

(2) Deadline for reporting and returning overpayments

An overpayment must be reported and returned under paragraph (1) by the later of –

(A) the date which is 60 days after the date on which the overpayment was identified; or

(B) the date any corresponding cost report is due, if applicable.

IDAHO Department of Health and Welfare May 08, 2017

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Magellan Medicaid Administration Resources

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[Pharmacy Claim Submission Specifications](#)
[Pharmacy FAQs and Notifications](#)

Payment Error Rate Measurement

[PERM Information Sheet](#)

Medicaid Program Integrity

[Idaho Medicaid Provider Exclusion List](#)
[Medicaid Provider Self Report Form](#)

FAQs

- [Revalidation](#)
- [ICD-10 FAQ](#)
- [Idaho Behavioral Health Plan](#)
- [Electronic Filing and Signature FAQs](#)
- [Frequently Asked Questions - Federally Funded Incentive Payments to Primary Care Service Providers](#)

Forms

- [EPSDT Request for Additional Services](#)
- [Long-Term Care Notification of Change](#)
- [Request to Transfer to Enhanced Plan Benefits \(H6002\)](#)
- [Hospital Inpatient - Notification of Birth for Medicaid Eligibility](#)
- [Optional Referral Form for Newborn Medicaid Coverage - HW2040](#)
- [Idaho Special Rate Request Form - Skilled Nursing Facility](#)
- [ICF/IID Special Rate Request Form](#)
- [ICF/IID Special Rate Leave of Absence Form](#)

Provider Training and Training Forms

Title

[Completion of NEW Level 1 Pre-admission Screening Resident Review WebEx Recording](#)

[Instructions for Completion of Level 1 Pre-admission Screening and Resident Review \(PASRR\) Frequently Asked Questions](#)

[Pre-Admission Screening and Resident Review \(PASRR\) Prescreen 87](#)

[Pre-admission Screening Resident - Review PowerPoint](#)

[Pre-admission Screening Resident Handouts - Review Handouts](#)

Policies

[Chiropractic Policy](#)
[Circumcision Policy](#)
[Consultation Services Policy](#)
[DME, DMS, and P&O for Participants Residing in an ICF/IID](#)
[Electronic Signature Policy](#)
[Forensic Exams Interviews](#)
[Interpretive Services](#)
[Ordering, Rendering, Prescribing Providers](#)
[Outpatient Genetic Rehabilitation Policy](#)
[Podiatry Policy](#)
[Telehealth Policy](#)
[Vision Policy](#)



Provider Self Report Form

Idaho Medicaid Program Integrity (MPI) is committed to protecting taxpayer dollars through prevention, detection and the elimination of fraud, waste and abuse in the Idaho Medicaid Program. These efforts help to protect our beneficiaries and ensure Idaho Medicaid has the resources to provide for their care. Health care providers are encouraged to help attain these goals through self-reporting of claim errors or overpayments.

Medicaid providers can refund overpayments by:

- adjusting or reversing claims through the Molina system
- completing an on-line Provider Self-Report Form

Examples of when to self-report:

- Incorrectly coded services
- Services were provided by an unlicensed or excluded individual
- Services were not rendered
- Services are outside the two-year period for adjusting claims

Per federal regulations, providers must report over payment and return overpayments within 60 days after identified.

Incentives for self-reporting:

- Extended repayment terms
- Waiver of civil monetary penalties
- Quick resolution of over payments

Provider Information

Provider Name:

Provider ID:

Address:

Contact Information

Contact Person/Title:

Phone Number:

Reason for Overpayment

- | | | |
|--|--|---|
| <input type="checkbox"/> Billing/coder error | <input type="checkbox"/> Insufficient/no documentation | <input type="checkbox"/> Service not rendered |
| <input type="checkbox"/> Duplicate billing | <input type="checkbox"/> Not our patient | <input type="checkbox"/> Unqualified staff |
| <input type="checkbox"/> Excluded employee | <input type="checkbox"/> Secondary payer issue | <input type="checkbox"/> Unlicensed staff |

Other (provide brief detail below):

Overpayment Amount:

Submit

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Contact Information

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Report Medicaid Fraud, Waste & Abuse

Phone - 208-334-5754

Fax - 208-334-2026

E-mail - prvfraud@dhw.idaho.gov

Online -

<https://healthandwelfare.idaho.gov/AboutUs/FraudReportPublicAssistanceFraud/ProviderFraudOnlineComplaintForm/tabid/3901/Default.aspx>

Mail

Medicaid Program Integrity Unit

PO Box 83720

Boise, Idaho 83720-0036

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Report Welfare Fraud, Waste & Abuse

Phone - 866-635-7515 (toll-free)

Fax - 208-334-5694

E-mail - welfraud@dhw.idaho.gov

Online -

<https://healthandwelfare.idaho.gov/AboutUs/FraudReportPublicAssistanceFraud/OnlineWelfareFraudReportingForm/tabid/1891/Default.aspx>

Mail

Welfare Fraud Investigations

PO Box 83720

Boise, Idaho 83720-0036

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Questions?



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