Reporting and Disclosure Requirements for Suspected or Confirmed Fraud:

Instructions for Submission of the Supplemental Referral Attachment

May 8, 2020

Within ten (10) days of providing advanced notice to MPI, the managed care plan must submit the supplemental referral attachment in a manner and format specified by the Agency. [Attachment II., Section X., Administration and Management, Sub-Section F., Fraud and Abuse Prevention Item 6.b.(2)]

The following describes the instructions for submission of the supplemental referral attachment, as required by Attachment II., Section X., Administration and Management, Sub-Section F., Fraud and Abuse Prevention Item 6.b.(2) of the Statewide Medicaid Managed Care contracts.

AT-A-GLANCE SUMMARY OF SUBMISSION REQUIREMENTS	
WHAT	Supplemental referral attachment
WHEN	Within ten (10) days of providing advanced notice to Medicaid Program Integrity (MPI)
WHERE	Agency's Office of MPI's MPI-MC SFTP site
SPECIAL INSTRUCTIONS	• Upload a single, scanned file • File must contain all of the supporting documentation providing evidence as specified in Detailed Submission Instructions (below) • File may be zipped to reduce the file size

DETAILED SUBMISSION INSTRUCTIONS

The supplemental referral attachment must be incorporated into a single, scanned file that includes documentation providing the following information, as recommended by Centers for Medicare & Medicaid Services in its 2008 Guidance regarding *Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units*:

a. **Subject:** name, Medicaid provider ID, address, provider type

b. **Source/origin of complaint**

c. **Date of origin of complaint:** This is the date on which the managed care plan initiated a review of the complaint or allegation.

d. **Description of suspected intentional misconduct, with specific details including:**

   i. *The category of service.*

   ii. *Factual explanation of the allegation:* The managed care plan should provide as much detail as possible concerning the names, positions, and contact information (if available) of all relevant persons; a complete description of the alleged scheme as it is understood by the Managed care plan, including, when possible, one or more examples of specific claims that are believed to be fraudulent; the manner in which the managed care plan came to learn of the conduct; and the actions taken by the managed care plan to investigate the allegations.

iii. *Specific Medicaid statutes, rules, regulations, or policies violated:* This information should include an explanation of why the conduct of the provider or individual violates the statutes, rules, regulations, or policies.

iv. *Date(s) of conduct:* When exact dates are unknown, the Managed care plan should provide its best estimate.

e. **Amount paid to the provider for the last three years or during the period of the alleged misconduct, whichever is greater:** This information should also include a claims detail with fields such as ICN, date of service, provider ID, recipient ID, diagnosis code, procedure code, and modifier.

f. **All communications between the managed care plan and the provider concerning the conduct at issue:** This section should include any communications that began with a question from the provider, provider enrollment documentation, and any education given to the provider as a result of past problems; as well as advisory bulletins, policy updates, or any other general communication to the provider community regarding the questionable behavior. Letters, emails, and phone logs are all sources of communication.

g. **Contact information for managed care plan personnel, including subcontractors, with practical knowledge of the workings of the relevant programs**

h. **Sample/exposed dollar amount, when available**: Exposed dollars should be categorized as *identified* exposed amount and *potential* exposed amount. Identified exposed amount is the dollar amount of specific claims that are believed to be fraudulent, when such amount may be determined. Potential exposed amount includes the identified exposed amount, if known, and is an estimated value of the totality of the scheme's financial impact.

The managed care plan must submit the supplemental referral attachment to the Agency's Office of MPI's MPI-MC SFTP site. Contact the Agency's MPI Business Manager (MPI Site Administrator) for access information via MPI-MCU@ahca.myflorida.com or 850-412-4600.