Program Integrity in Tennessee: TennCare Oversight – Activities - Coordination

DENNIS J. GARVEY, JD
DIRECTOR, OFFICE OF PROGRAM INTEGRITY
BUREAU OF TENNCARE
What is TennCare?

• TennCare is the Tennessee Medicaid program, serving approximately 1.2 million enrollees at a cost of $9.7 billion per year.

• We are 100% managed care.
Our Program Integrity Team

- Dennis J. Garvey, JD
  - Director

- Investigations
  - Chief & Seven Investigators: Four Certified Coders, Four RN’s

- Payment Integrity & Data Mining Analytics
  - Chief & Eleven Analysts

- Project Management
Use of Data Mining

- We have a dedicated staff of data miners. Staff are well-educated, varying in educational levels from that of Ph.D. to Associate’s Degree.

- Data Mining is performed on Encounter Data both:
  - As a matter of Routine, and
  - In response to a Tip or Allegation received.
Use of Investigators

We have two (2) types of employees who perform investigations:

- Registered Nurses; and
- Certified Coders.

In addition, other educational credentials are held by this staff, such as Certified Fraud Examiner (CFE). We are also proud to have one of a very few individuals in the nation to have achieved status as a Certified Program Integrity Professional (CPIP).
To ensure accuracy...

ALL Investigation Reports are cross-reviewed between these employees to ensure that a complete and thorough investigation is performed and well-documented.
Referrals for investigations

- Internet (through a hot button link)
- Hotline Reporting through partner agencies
- Data Mining
- MCC referrals
- Anonymous tips from the public
- Links discovered through doing another investigation
- Anywhere we can!
What happens next?

- Once TBI MFCU and/or the AG accept a case for prosecution, we no longer have the case.

- If the TBI MFCU and the AG both reject a case, we continue to have control of the case.
If TennCare retains ownership of a case…

• We may handle any administrative actions relating to the case,
  or
• We may choose to return the case to the MCC for any further action; including, but not limited to, recoupment and/or education.
What about enrollee crime?

In Tennessee, TennCare enrollee crime is identified, investigated and prosecuted by the Office of the Inspector General (OIG).

TennCare OPI works closely with OIG to combat fraud and abuse of the Medicaid program in Tennessee.

For more information, go to: http://tn.gov/tnoig/
TennCare’s Contractors

- Three (3) Managed Care Companies
- Dental Benefit Manager
- Pharmacy Benefit Manager
- Recovery Agent Contractor (RAC)
Why are TennCare PI efforts successful?

- All these entities are interested in making and keeping every dollar that they can.

- TennCare PI is interested in ensuring that all of this is done properly - according to State and Federal law; and the terms of each respective contract.
Program Integrity Efforts: MCCs

Each TennCare-contracted MCC must submit a detailed Quarterly Fraud and Abuse Report, in a format prescribed by TennCare.

- Staff in OPI Payment Integrity & Data Mining Analytics review each of these reports.
- Each quarter, OPI leadership holds a meeting with each of the plans and other interested parties to discuss.
TennCare MCC Terms

- Six (6) month contract amendments
- On-Request Reports (ORR)
- Liquidated damages
- Request for Information (RFI)
- Meeting Invites
- Contract terms that MCC must include in provider contracts
Quarterly Fraud & Abuse Activities Report

This report contains the following tabs:

- Summary
- TIPS
- Audits Performed
- Referrals Made
- Overpayments Identified
- Overpayments Recovered
- New PI Actions
- List of Involuntary Terminations
- List of Recipients Referred to OIG
## Quarterly Report: Summary

<table>
<thead>
<tr>
<th>Activity Reporting Quarter</th>
<th>MC0 Summary Statistics</th>
<th>MC0 Summary Statistics</th>
<th>MC0 Summary Statistics</th>
<th>MC0 Summary Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01 - 03/31/2013</td>
<td>1</td>
<td>12</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

- **# with Overpayment Identified**
- **# without Overpayment Identified**
- **Total**
- **New**
- **Existing**

Security Warning: Automatic update of links has been disabled.
## Quarterly Report: TIPS

<table>
<thead>
<tr>
<th>Activity Quarter</th>
<th>MCC Tracking</th>
<th>Received Date</th>
<th>Closed Date</th>
<th>Status</th>
<th>Source</th>
<th>TIP Allegation/Information</th>
<th>First Name</th>
<th>Last Name</th>
<th>NPI</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q 2013</td>
<td>23456MCO</td>
<td>2/15/13</td>
<td>N/A</td>
<td>Still Open</td>
<td>Phone Call</td>
<td>Provider billing for new patient when patient was seen 12 months ago.</td>
<td>Silly</td>
<td>Silly</td>
<td>Test Field</td>
<td>Test Field</td>
</tr>
<tr>
<td>4Q 2012</td>
<td>12345MCO</td>
<td>11/2/12</td>
<td>11/26/22</td>
<td>TIP Unfounded</td>
<td>Data Mining</td>
<td>Hospital allegedly used incorrect diagnosis code when billing for cardiovascular inpatient admits. This may have caused incorrect DRG to be assigned to inpatient admits.</td>
<td>Bill</td>
<td>Menny</td>
<td>Test Field</td>
<td>Test Field</td>
</tr>
<tr>
<td>4Q 2012</td>
<td>12345MCO</td>
<td>11/2/12</td>
<td>1/19/18</td>
<td>Still Researching</td>
<td>News Media In Investigating</td>
<td>Provider allegedly billed medically unnecessary services. Exposure is estimated at $2,000,000.</td>
<td>Shanevia Jones</td>
<td>Test Field</td>
<td>Test Field</td>
<td>Test Field</td>
</tr>
</tbody>
</table>

**Note:**
- **TIPS** stands for **Transactions Identification and Public Disclosure System**.
- This report includes information on various activities, such as provider billing issues, data mining errors, and potential fraud incidents.
- The report is designed to help identify and address fraudulent activities within the healthcare system.
# Quarterly Report: Audits Performed

## 2013 Template for Quarterly Fraud and Abuse Activities Report

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>NPI</th>
<th>TIN</th>
<th>Audit Reason</th>
<th>Type of Audit (Medical Records)</th>
<th>MCO Operational Department</th>
<th>Audit Findings</th>
<th>Overpayments Identified related to TeamCare</th>
<th>Reimbursement Amount related to TeamCare Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Big</td>
<td>Ortho</td>
<td>TestField</td>
<td>TestField</td>
<td>Desk Audit</td>
<td>Desk Audit</td>
<td>MDU</td>
<td>10 claims were audited against medical records and 6 anomalies were found. No corrective action plan was developed.</td>
<td>$20,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>St. Mary's Hospital</td>
<td>TestField</td>
<td>TestField</td>
<td>Desk Audit</td>
<td>Desk Audit</td>
<td>MDU</td>
<td>25 claims were audited against medical records and FQHC billing guidelines and 7 anomalies were found. Educational materials will be provided. Top corrective actions needed.</td>
<td>$30,000</td>
<td>$20,000</td>
<td></td>
</tr>
<tr>
<td>Local Public Hospital</td>
<td>TestField</td>
<td>TestField</td>
<td>Desk Audit</td>
<td>Desk Audit</td>
<td>MDU</td>
<td>100 hospital claims were audited against medical records and 50 anomalies were found. Top corrective actions needed. No corrective action plan was developed.</td>
<td>$50,000</td>
<td>$30,000</td>
<td></td>
</tr>
</tbody>
</table>

### Notes

- All claims reviewed were found to be accurate and within guidelines.
- No corrective actions needed.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>NPI</th>
<th>TIN</th>
<th>Audit Reason</th>
<th>Type of Audit (Medical Records)</th>
<th>MCO Operational Department</th>
<th>Audit Findings</th>
<th>Overpayments Identified related to TeamCare</th>
<th>Reimbursement Amount related to TeamCare Sessions</th>
</tr>
</thead>
</table>

### Additional Information

- All claims reviewed were found to be accurate and within guidelines.
- No corrective actions needed.
# Quarterly Report: Referrals Made

![Spreadsheet Image]

The spreadsheet contains data related to referrals made, including dates, sources, and notes. Each row represents a referral with details such as the date (e.g., 06/2012), source (e.g., EMERGENCY), and notes (e.g., All referrals made per EMERGENCY). The spreadsheet also includes columns for First Name, Last Name, NPI, and TIN.
## Quarterly Report: Overpayments Identified

<table>
<thead>
<tr>
<th>Activity Quarter</th>
<th>MCC Tracking#</th>
<th>First Name</th>
<th>Last Name</th>
<th>TIP</th>
<th>TIN</th>
<th>How was Overpayment Identified</th>
<th>Identified Overpayment Amounts Related to TennCare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q, 2013</td>
<td>12345MCO</td>
<td>Min</td>
<td>Wounded Knee</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Initial TIP claimed Provider was billing for services referred to another entity and not performed in provider’s</td>
<td>$150,000</td>
</tr>
<tr>
<td>1Q, 2013</td>
<td>12345MCO</td>
<td>Naperville East</td>
<td>Hospital</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Data mining found provider billing for E&amp;M codes along with DME codes. Provider agreed with MCC policy and to refund overpayments</td>
<td>$58,000</td>
</tr>
</tbody>
</table>

The Bureau is not looking for overpayments related to administrative errors such as incorrect patient identifier, incorrect provider ID, incorrect dates of service, etc. Instead, we are focused on overpayments that are the result of FWA.
Quarterly Report: Overpayments Recovered

<table>
<thead>
<tr>
<th>Activity Quarter</th>
<th>MCC Tracking#</th>
<th>First Name</th>
<th>Last Name</th>
<th>TIP</th>
<th>TIN</th>
<th>How was Overpayment Identified</th>
<th>Recovered Overpayment Amounts Related to TennCare Services</th>
<th>Overpayment Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q, 2013</td>
<td>12345MCO</td>
<td>Min</td>
<td>Wounded Knee</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Initial TIP claimed Provider was billing for services referred to another entity and not performed as provider's</td>
<td>$100,000</td>
<td>Check</td>
</tr>
<tr>
<td>2Q, 2013</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td></td>
<td>$1,000</td>
<td></td>
</tr>
<tr>
<td>3Q, 2013</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td></td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>4Q, 2013</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1Q, 2014</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2Q, 2014</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
<td></td>
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<tr>
<td>3Q, 2014</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
<td>Text Field</td>
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<tr>
<td>4Q, 2014</td>
<td>12345MCO</td>
<td>Text Field</td>
<td>Text Field</td>
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</table>

TennCare is focused on recoveries related to FPA and not administrative error. Do not pursue recoveries with providers that are under TBI/MFCU investigation, wait until it has been approved to pursue recoveries.
Quarterly Report: New PI Actions
## Quarterly Report: List of Involuntary Terms

<table>
<thead>
<tr>
<th>Provider EIN</th>
<th>Termination Type 1 (see the list of codes to be used)</th>
<th>Termination Type 2 (see the list of codes to be used)</th>
<th>Termination Type 3 (see the list of codes to be used)</th>
<th>Description of Terminating Concerns</th>
<th>Date of Termination</th>
<th>Notified Third Party (Y/N)?</th>
<th>Date of Notification to Third Party</th>
<th>Notified PDES (Y/N)?</th>
<th>Other Notified Parties</th>
<th>Date of Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test Field</td>
<td>MT-08</td>
<td></td>
<td></td>
<td>Listing for related case rendered</td>
<td>1/01/2023</td>
<td>Y</td>
<td>1/01/2023</td>
<td>HHC-06</td>
<td>State Agency</td>
<td>1/01/2023</td>
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</tbody>
</table>
### Quarterly Report: List of Recipients Referred to OIG

#### Table: List of Recipients Referred to OIG

<table>
<thead>
<tr>
<th>Week</th>
<th>NAID</th>
<th>Name</th>
<th>DOB</th>
<th>Phone</th>
<th>Email</th>
<th>State of Residence</th>
<th>FBI/DOJ</th>
</tr>
</thead>
</table>
Other Program Integrity Efforts

- MCC Internal Program Integrity Operations
- MCC-Contracted Program Integrity Operations
- Other State Auditors (Comptroller, DHS, etc.)
- Federal Auditors (Both internal and contracted)
- TennCare-Contracted Auditors
- TBI-MFCU
- Attorney General
“The CONTRACTOR shall have methods for identification, investigation, and referral of suspected fraud cases...”

Specific references are found in 42 CFR 455.13, 455.14, & 455.21.
Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that—
   (1) Do not infringe on the legal rights of persons involved; and
   (2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.
TennCare MCC Contract Language

- All confirmed or suspected provider fraud and abuse shall immediately be reported to TBI MFCU and TennCare Office of Program Integrity; and
- All confirmed or suspected enrollee fraud and abuse shall be reported immediately to OIG.

AND

A. The CONTRACTOR shall use the Fraud Reporting Forms in Attachment VI, or such other form as may be deemed satisfactory by the agency to whom the report is to be made under the terms of this Agreement.
The CONTRACTOR ... after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, shall not take any of the following actions as they specifically relate to TennCare claims:

• Contact the subject of the investigation about any matters related to the investigation;
• Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
• Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
A. The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CONTRACTOR employees and consultants, including but not limited to, those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
“...The CONTRACTOR and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of TennCare payment, that the provider comply with this Section, Section 2.20 of this Agreement.”

MCC Contracts are where you should articulate every single thing that you either want or need for a provider to do regarding Fraud, Waste and Abuse.
Contract Definitions

Well-stated contract definitions:
- Can eliminate questions,
- Help you on a Program Integrity basis, and
- Are as inclusive and/or exclusive as you want them to be.

To ensure legal consistency and accuracy, partner with your State’s internal counsel. Your attorneys should be your friends!

Don’t ignore contract definitions. They can make or break a case.
Some terms we use in TN:

- Administrative Cost
- Adverse Action
- Base Capitation Rate
- Benefits
- “Clean Claim”
- Contract Provider
- Eligibility
- Repayment
Other reasons for oversight of MCOs:

MCO Fraud and Abuse Risks:
- Risk Adjustment Manipulation
- Underutilization/Denial of Care
- Financial Reporting Fraud
- “Lemon-Dropping”
- Marketing Fraud
The elephant(s) in the room...

Liquidated Damages

and

Withholds
REMEMBER!

You are paying the MCC for the care and services they provide to your beneficiaries.

The customer is always right.

You control the $$$.
Liquidated Damages and Withholds

Even though MCCs are our “partners”:

- All Medicaid-Contracted MCCs have a distinct contractual obligation to meet their contractual standards, as well as State and Federal mandates for reporting and investigations.

- If the MCC fails to meet these requirements and/or mandates, liquidated damages (LD) and/or withholds (WH) may be levied against them. The amount of the LD may vary in relationship to the weight of the offense committed. WH may result in the permanent loss of income to the MCC.
History of TennCare Program Integrity

- Tennessee Medicaid became “TennCare” in 1993.
- We were told, “There’s no fraud in Managed Care!”
- One staff member was assigned to Program Integrity, Estate Recovery, Third-Party Liability and Special Projects.
- For the first ten (10) years of TennCare – that was it!
- Next addition to staff was a Data Analyst in 2003.
- In 2011, OPI staff comprised of twenty-three (23) staff.
Governing OPI: False Claims Act (FCA)

1. Expand FCA liability to indirect recipients of federal funds
2. Expand FCA liability for the retention of overpayments, even where there is no false claim
3. Add a materiality requirement to the FCA, defining it broadly
4. Expand protections for whistleblowers
5. Expand the statute of limitations
6. Provide relators with access to documents obtained by government
TennCare Uses Data to Detect Overpayments

We can routinely look at data for:

- Excluded persons
- Deceased enrollees
- Deceased providers
- Credit balances
Federal False Claims

Federal Law:

- (a) **Liability for Certain Acts.**—(1) In general...any person who—
  - (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
  - (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
(2) “claim”—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

- (i) is presented to an officer, employee, or agent of the United States; or
- (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government—
  - (I) provides or has provided any portion of the money or property requested or demanded; or
  - (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded...
(a) Any person who:

(1) (A) Presents, or causes to be presented, to the state a claim for payment under the medicaid program knowing such claim is false or fraudulent;

...Is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), plus three (3) times the amount of damages which the state sustains because of the act of that person.
"Claim" includes any request or demand for money, property, or services made to any employee, officer, or agent of the state, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded was issued from, or was provided by, the state.
TennCare may bring an action as an administrative proceeding on behalf of the state for recovery under § 71-5-182 against any person specified by the attorney general and reporter other than an enrollee, recipient or applicant.
The amount of actual damages that the state may seek in such administrative proceeding shall not exceed twenty five thousand dollars ($25,000). This limit shall not apply to any civil penalties or costs that the state is eligible to recover under.

Notwithstanding..., the civil penalty for each violation of § 71-5-182 in such administrative proceeding shall be not less than one thousand dollars ($1,000) and not more than five thousand dollars ($5,000).

TennCare uses statistically valid random samples (SVRS) of records for recovery investigations to decrease the amount of records for a review. Extrapolation of the records review is permitted under Tennessee law.
All providers who wish to participate in the TennCare program must register with TennCare and receive a unique provider number.

TennCare controls this process, utilizing on-line registration through CAQH.

Individual persons register through a secure electronic portal.

Individual entities submit paper applications.
TennCare Providers

- TennCare receives all relevant data relating to providers, including, but not limited to, information on:
  - Ownership and Control
  - Licensure
  - Residency
  - Place of Business
  - Date of Birth
  - Adverse Actions
Providers are required to have a TennCare-issued provider identification number in order to bill for services or goods supplied to a TennCare-eligible enrollee.

TennCare controls the ability to issue, suspend or revoke the TennCare-issued provider identification number.

This control ensures our ability to manage the providers in our program.

Examples: Credible Allegation of Fraud, Loss of Licensure, on Federal Exclusion Databases
TennCare Internal Partners

- Provider Enrollment
- Managed Care operations
- Data Integrity
- Fiscal
- Medical Director
- Behavioral Health
- Pharmacy
- Dental
- Long-term Support Services
- Office of General Counsel
- Eligibility
- Electronic Health Records
Credible Allegation of Fraud

- State agency (TennCare) makes determination of credible allegation of fraud that has “indicia of reliability”
- Can come from any source:
  - Complaint made by former employee
  - Fraud hotline
  - Claims data mining
  - Patterns identified through:
    - Audits
    - Civil false claims
    - Investigations
Credible Allegation of Fraud

If a credible allegation is identified:

TennCare checks to ensure there is not a good cause exception and then decides whether to suspend and by how much, after which TennCare will inform the other regulating agencies of the determination.

- If there’s not a credible allegation:
  
  For example, there was a data error which caused the provider to look like an outlier, but wasn’t. No suspension is placed into effect.

**TAKEAWAY:** In accordance with federal guidance, TennCare will review all evidence and carefully consider the totality of facts and circumstances.
• “RAC” stands for Recovery Agent Contractor

• Pursuant to the Affordable Health Care Act, the State has established a program under which it will contract with one (or more) recovery audit contractors (RACs). This contract is for the purpose of identifying underpayments and overpayments of Medicaid claims under both the State plan and under any waiver of the State plan.
Mr. Darin J. Gordon, Director  
Department of Finance and Administration  
Bureau of TennCare  
310 Great Circle Rd  
Nashville, TN 37243

Re: Tennessee Title XIX State Plan Amendment, Transmittal #11-012

Dear Mr. Gordon:

We have reviewed Tennessee State Plan Amendment (SPA) 11-012, which was submitted to the Atlanta Regional Office on November 7, 2011. This amendment requested an exemption to the required three (3) year look-back period by the Medicaid Recovery Audit Contractor (RAC). Due to Tennessee’s Medicaid program being operated as a managed care delivery system and to allow the Managed Care Contractors time to complete their internal claims processing and program integrity operations, CMS approves an exemption with a five (5) year look-back period.

Based on the information provided, the Medicaid State Plan Amendment 1N 11-012 was approved on February 3, 2012. The effective date of this SPA is November 15, 2011. The signed HCFA-179 and the approved plan pages are enclosed.

If you have any questions regarding this amendment, please contact Kenni Howard at (404) 562-7413.

Jackie Glaze  ~by David Kimble  
Associate Regional Administrator  
Division of Medicaid & Children’s Health Operations

Enclosures
Look-back Period

CMS has granted approval for TennCare to look-back five (5) years from the date of a paid claim.
What does RAC cover?

- All TennCare Providers
- All TennCare claims (Fee-for-service, Encounter and Capitation)
- All improper payments, including, but not limited to:
  - Incorrect payments
  - Non-covered services
  - Incorrectly coded services
  - Duplicate services
  - Services not rendered
  - Excessive Reimbursements
  - Reimbursement Errors
  - Coverage or Eligibility Errors
Types of RAC Audits

- **Automated Audits**
  - Data Matching
  - Data Mining
  - Desk Audits

- **Complex On-site Audits**
  - Financial
  - Clinical
Additional RAC Requirements

- The contractor shall refer any and all suspected fraud cases to the Bureau of TennCare.

- TennCare will coordinate the payment integrity efforts of the MCOs, the PBM and DBM and remove them from HMS reviews as appropriate.
TennCare Uses Data to Detect Overpayments

- Excluded persons
- Deceased enrollees
- Deceased providers
- Credit balances
Reporting Allegations To TennCare

PHONE
Fraud Hotline
1-800-433-3982
Fax: 615-256-3852

EMAIL
Go to:
www.tncarefraud.tennessee.gov
or email us at:
Programintegrity.TennCare@tn.gov

MAIL
Bureau of TennCare
Office of Program Integrity
310 Great Circle Road
Nashville, TN 37243