Centennial Care Reporting Instructions
Program Integrity – Report #56

Report Objective

To monitor the program integrity activities of the Manage Care Organization (MCO) as it relates to fraud, waste, and abuse. Specifically, the MCO's preliminary investigations, audits, reviews, suspicious activities, adverse actions and performance.

General Instructions

The MCO is required to submit the Program Integrity Report (Report – a template using a Microsoft Excel spreadsheet identified as "Report 56 – v5.xlsx") quarterly on a calendar year (CY) basis. The MCO shall use a new (blank) Report at the beginning of each CY (note, some data from the previous CYs may need to be considered when completing the Report for the current reporting period). Please adhere to the following quarterly reporting periods and due dates:

Quarter	Reporting Period	Report Due Date
1	January 1 – March 31	April 30
2	April 1 – June 30	July 30
3	July 1 – September 30	October 30
4	October 1 – December 31	January 30

The following applies to Sections I, III, IV, V and VI of these Reporting Instructions. Each time the Report is submitted, the MCO shall use the same Report that was submitted in the previous quarter for the current calendar year. For example, the Report due on July 30th will include data for the 1st and 2nd quarters. The 2nd quarter would be 1/1/XX through 6/30/XX and include data for the first 2 quarters combined. The MCO shall not alter data that was previously submitted, unless stated explicitly in these instructions.

The Report consists of eight worksheets or tabs that correlate to the eight sections discussed in these Reporting Instructions. There is a ninth tab, titled "Reference" that provides reference information for the Report build and is not used by the MCO. Quantitative data and any qualitative data requested **must** be entered in the Report. The MCO must ensure that data is entered in all fields. The Report will be considered incomplete if any field is left blank. Use "ND" if there is no data available to report. Use "N/A" if the data field is not applicable. All formulas provided in the Report shall **not** be altered by the MCO. An electronic version of the Report must be submitted to the New Mexico Human Services Department (HSD), Centennial Care Contracts Bureau (CCCB) by the Report due date listed above. The Report shall be submitted via Xerox's MOVEit DMZ Enterprise secure file transfer server (also known as the State's secure DMZ FTP site). The day the electronic version of the Report is received by HSD-CCCB will serve as the date of receipt.

To assist MCOs with the use of the Report, all cells within the Report are viewable. This allows the MCO to move the cursor into any cell and enables the MCO to see the formulas in the cells that calculate automatically. Although certain cells are locked and protected, the MCO's ability to view the formulas should assist in the MCO's understanding of the Report and calculations performed. It is important to note that when populating the Report with data, MCOs are not to use the "cut and paste" function in Microsoft Excel or from any other source, as this may cause errors to the cell formulas. Additionally, certain cells have been shaded and locked to prevent data entry where data is not applicable to the particular item or category.

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The MCO shall submit the electronic version of the Report using the following file labeling format: MCO.HSD56.Q#CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each Report submission, change the quarter reference (Q# - e.g., Q1), the calendar year (CY## - e.g., CY16), and the version number (v# - e.g., v1), as appropriate. The version number should be "1" unless the MCO is required to resubmit a Report for a specified quarter. In those instances, the MCO will use "2" and so on for each resubmission.

The Quarter, MCO Name, and Report Run Date must be entered in the fields provided at the very top left corner of the tab identified as "Summary" in the Report. Using the format illustrated below, enter the start and end dates for the Quarter. The MCO Name should be the MCO's full business name. Using the format illustrated below, enter the Report Run Date. The Report Run Date refers to the date that the data was retrieved from the MCO's system. All dates and the MCO name entered on the Summary tab will automatically populate the top of all other tabs in the Report.

Quarter	MM/DD/YYYY	through	MM/DD/YYYY
MCO Name	MCO's Full Name		
Report Run Date	MM/DD/YYYY		

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in each of the tabs prior to submitting the Report. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports may result in liquidated damages of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each Report submitted. Failure to submit a signed attestation form by the Report due date will result in the entire Report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in liquidated damages of $1,000 per report, per calendar day. The $1,000 per calendar day damage amounts will double every ten calendar days.

Related Contract and Regulatory Requirements

1. Contract Section 4.21 – Reporting Requirements
2. Contract Section 7.3 – Failure to Meet Agreement Requirements
3. Contract Section 4.17.2.4 – Program Integrity
4. Contract Section 7.27 – Cooperation Regarding Fraud
5. Title 42 C.F.R 455, Subpart A – Medicaid Agency Fraud Detection and Investigation Program

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Definitions

Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to Medicaid, or the interagency Behavioral Health Purchasing Collaborative (the Collaborative), in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes caregiver, client or member/representative practices that result in unnecessary costs to Medicaid or the Collaborative.
Adverse Actions	An adverse action can be classified as one or more of the following: (1) Suspension or revocation of a license to provide health care by any State licensing authority; (2) Suspension or revocation by an accreditation organization; (3) A conviction of a Federal or State felony offense (as defined in Title 42 CFR § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; (4) An exclusion or debarment from participation in a Federal or State health care program; or (5) Denial of credentialing or enrollment of a Provider where denial of credentialing or enrollment is due to concerns **other than fraud**, such as integrity or quality, or termination.
Caregiver	A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost. For purposes of the Report, a caregiver is typically an employee of a Provider.
Egregious	Extraordinary in some bad way; conspicuously and outrageously bad or reprehensible; very bad and easily noticed; glaring; flagrant.
Fraud	An intentional deception or misrepresentation made by an entity or person, including but not limited to: MCO, subcontractor, provider, caregiver, or client, with the knowledge that the deception could result in some unauthorized benefit to themselves or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.
Investigative Activity	An MCO investigative action resulting in information that is significant and relevant to the investigation. This may include, but is not limited to, interview, document analysis, document receipt, etc.
Member/Representative	A person who has been determined eligible for Centennial Care and who has enrolled in the state's Medicaid program.
Provider	An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished. Providers can include individuals and vendors providing services to Member/Representatives through the Self-Directed Community Benefit.

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Suspicious Activity	Any activity that does not make sense to the MCO, is unusual, not normal, or out-of-place for a Provider, Caregiver, or Member/Representative, or appears to be done only for the purpose of hiding or obfuscating an action. The activity witnessed is based on a belief or opinion based on facts or circumstances that do not constitute proof.
Waste	Not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by person(s) or entities with control over or access to government resources (e.g., executive, judicial, or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse, and does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions, and inadequate oversight.

Section I: Summary

Before entering data in this section, ensure that the "Summary" tab is selected. This section of the Report provides summary data on the number of open and closed fraud, waste, and abuse cases for the quarter. Ensure this tab in the Report is updated each quarter in order to collect cumulative data.

Columns E/I/M/Q in the Report captures the quarterly total and will automatically sum or calculate; data entry is not required in these fields.

The following fields and descriptions are in the Summary tab under column A in the Report and are as follows:

Row Header	Row	Description
Provider Cases	8	This is a row header; data entry is not required in these fields.
Number of Provider Cases Opened During the Month for the Quarter Being Reported	9	The number of Provider fraud, waste, and abuse cases that were opened during the applicable month for the quarter being reported. The date the MCO identified fraud, i.e. through an audit, or received the allegation(s) should count as the date the case was opened.
Number of Provider Cases Carried Over from the Previously Reported Month	10	The number of Provider fraud, waste, and abuse cases that were carried over from the previously reported month that were unresolved (open) on the first day of the current reporting month. Note: See the previous month's "Total Number of Provider Cases Open at the End of the Applicable Month" (Row 12). For a new CY, retrieve December's total for January's entry.
Number of Provider Cases Closed During the Month for the Quarter Being Reported	11	The number of Provider fraud, waste, and abuse cases that were resolved (closed) during the applicable month for the quarter being reported. Note: This count includes Provider cases that were closed

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Row Header	Row	Description
		with or without findings. If the case was referred to the HSD/Office of Inspector General (OIG) and is no longer being investigated by the MCO, the case should be considered closed and included in the count. The date the MCO made the referral should count as the date the case was closed. For those cases with no findings, the date of last recorded investigative activity (see definition above) should be used.
Total Number of Provider Cases Open at End of the Month for the Quarter Being Reported	12	The sum of the "Number of Provider Cases Opened During the Month for the Quarter Being Reported" (Row 9) plus the "Number of Provider Cases Carried Over from the Previously Reported Month" (Row 10) minus the "Number of Provider Cases Closed During the Month for the Quarter Being Reported (Row 11). Note: The Report will automatically calculate; Data entry is not required in these fields.
Member/Representative Cases	13	This is a row header; data entry is not required in these fields.
Number of Member/Representative Cases Opened During the Month for the Quarter Being Reported	14	The number of Member/Representative fraud, waste, and abuse cases that were opened during the applicable month for the quarter being reported. The date the MCO identified fraud, i.e. through an audit, or received the allegation(s) should count as the date the case was opened.
Number of Member/Representative Cases Carried Over from the Previously Reported Month	15	The number of Member/Representative fraud, waste, and abuse cases that were carried over from the previously reported month that were unresolved (open) on the first day of the current reporting month. Note: See the previous month's "Total Number of Member/Representative Cases Open at the End of the Applicable Month" (Row 17). For a new CY, retrieve December's total for January's entry.
Number of Member/Representative Cases Closed During the Month for the Quarter Being Reported	16	The number of Member/Representative fraud, waste, and abuse cases that were resolved (closed) during the applicable reporting month for the quarter being reported. Note: This count includes Member/Representative cases that were closed with or without findings. If the case was referred to HSD/OIG and is no longer being investigated by the MCO, the case should be considered closed and included in the count. The date the MCO made the referral should count as the date the case was closed. For those cases with no findings, the date of last recorded investigative activity should be used.

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Row Header	Row	Description
Total Number of Member/Representative Cases Open at End of the Month for the Quarter Being Reported	17	The sum of the "Number of Member/Representative Cases Opened During the Month for the Quarter Being Reported" (Row 14) plus the "Number of Member/Representative Cases Carried Over from the Previously Reported Month" (Row 15) minus the "Number of Member/Representative Cases Closed During the Month for the Quarter Being Reported (Row 16). Note: The Report will automatically calculate; Data entry is not required in these fields.
Caregiver Cases	18	This is a row header; data entry is not required in these fields.
Number of Caregiver Cases Opened During the Month for the Quarter Being Reported	19	The number of Caregiver fraud, waste, and abuse cases that were opened during the applicable month for the quarter being reported. The date the MCO identified fraud, i.e. through an audit, or received the allegation(s) should count as the date the case was opened.
Number of Caregiver Cases Carried Over from the Previously Reported Month	20	The number of Caregiver fraud, waste, and abuse cases that were carried over from the previously reported month that were unresolved (open) on the first day of the current reporting month. Note: See the previous month's "Total Number of Caregiver Cases Open at the End of the Applicable Month" (Row 22). For a new CY, retrieve December's total for January's entry.
Number of Caregiver Cases Closed During the Month for the Quarter Being Reported	21	The number of Caregiver fraud, waste, and abuse cases that were resolved (closed) during the applicable reporting month for the quarter being reported. Note: This count includes Caregiver cases that were closed with or without findings. If the case was referred to HSD/OIG and is no longer being investigated by the MCO, the case should be considered closed and included in the count. The date the MCO made the referral should count as the date the case was closed. For those cases with no findings, the date of last recorded investigative activity should be used.
Total Number of Caregiver Cases Open at End of the Month for the Quarter Being Reported	22	The sum of the "Number of Caregiver Cases Opened During the Month for the Quarter Being Reported" (Row 19) plus the "Number of Caregiver Cases Carried Over from the Previous Reported Month" (Row 20) minus the "Number of Caregiver Cases Closed During the Month for the Quarter Being Reported (Row 21).

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Row Header	Row	Description
		Note: The Report will automatically calculate; Data entry is not required in these fields.
Total Fraud, Waste, and Abuse Cases	23	This is a row header; data entry is not required in these fields.
Total Number of Fraud, Waste, and Abuse Cases **Open** at End of Each Reporting Month	24	The sum of the total number of Provider, Member/Representative, and Caregiver cases open at the end of each reported month. Note: The Report will automatically sum these columns. Data entry is not required in these fields.
Total Number of Fraud, Waste, and Abuse Cases **Closed** During each Reported Month	25	The sum of the total number of Provider, Member/Representative, and Caregiver cases closed during each reported month. Note: The Report will automatically sum; Data entry is not required in these fields.

Section II: Analysis

Before entering data in the Report, ensure that the "Analysis" tab is selected. This section of the Report collects qualitative information regarding Provider, Member/Representative, and Caregiver suspicious activity. For each question, include any changes identified and trends over time when compared to previous reporting quarters or CYs and provide an explanation of the identified changes or trends. Additionally, describe any action plans or performance improvement activities addressing any negative changes found during the reporting quarter. The questions below are contained in the Report:

1. Based on open investigations, what Provider types (e.g., Fee-For-Service, Ambulatory Surgical Centers, Ambulatory Services, Anesthesiologists, Clinical Labs, Critical Access Hospitals, Durable Medical Equipment, Federally Qualified Health Centers, Home Health Agency, Hospice, Hospital, Practice Administration, Pharmacist, Physician, Rural Health Clinics, Skilled Nursing Facility, etc.) are committing the most egregious abuse with the potential for fraud referrals? (This question applies to Centennial Care cases only.) How does this compare to previously reported quarters or CYs?

   The MCO is required to identify outliers, depending on the service type, diagnosis code, or other criteria to determine overutilization. Based on this information, the MCO should be able to quantify the "most egregious" either by dollars spent (or overspent) or services (such as, a practitioner billing more than 24 hours in a given day).

2. Based on open investigations, which geographical area(s) experience the most Provider, Member/Representative, and Caregiver fraud, waste, and abuse with the potential to be referred? (This question applies to Centennial Care cases only.) A distinction should be made between Provider, Member/Representative, and Caregiver in the MCO's response. How does this compare to previously reported quarters or CYs?

3. For all Provider allegations that require preliminary investigations and that are classified as "399 - Miscellaneous not elsewhere specified (Provider)" from the "Provider Investigations" tab of the Report (for reference, also see the instructions in Section III below), provide the MCO's description of the allegation(s) being investigated and label each description with the Provider name and National Provider Identifier (NPI) number.

4. For all Member/Representative allegations that require preliminary investigations that are classified as "199 - Miscellaneous not elsewhere specified (Member/Representative)" from the "Member/Representative Investigations" tab of the Report (for reference, also see the instructions in Section IV below), provide the MCO's description of the allegation(s) being investigated and label each description with the Member/Representative name and Medicaid Identification number.

5. For all Caregiver allegations that require preliminary investigations that are classified as "499 - Miscellaneous not elsewhere specified (Caregiver)" from the "Caregiver Investigations" tab of the Report (for reference, also see the instruction in Section V below), provide the MCO's description of the allegation(s) being investigated and label each description with the Caregiver name and as much detailed identifying information for the Caregiver, i.e. full name, last four digits of social security number, date of birth, address, phone number, employer, etc.

6. Provide additional detail on the reason for termination for Provider applications listed as "other" in Column G in the "Adverse Actions" tab of the Report (for reference, also see the instruction in Section VIII below).

Section III: Provider Investigations

Before entering data in the Report, ensure that the "Provider Investigations" tab is selected. This section of the Report captures the number of Provider preliminary investigations that have been referred to or identified by the MCO for incidents of suspected and/or confirmed fraud, waste, and abuse.

For each month of the reporting quarter, enter the number of Provider fraud, waste, and abuse cases that were opened based on initial allegation codes provided in the Report. If a Provider allegation(s) fits more than one code, please select the most appropriate code.

Columns E/I/M/Q in the Report capture the quarterly total for each row outlined and will automatically sum; data entry is not required in these fields. Column R captures the year to date total for all measures and will automatically sum; data entry is not required in this field.

The following codes and descriptions are in the Provider Investigations tab under column A in the Report and are as follows:

Row Header	Row Number
205 – Audit claims (Provider)	8
210 – Intentionally Left Blank	9
301 – Use of unlicensed staff (Provider)	10
302 – Kickbacks (Provider)	11
303 – Billing for services not rendered (Provider)	12

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Row Header	Row Number
304 – Up-coding/Unbundling issues (Provider)	13
304A – Unbundled charges (Provider)	14
304B – Up-coded charges (Provider)	15
304C – Split billing/serial billing (Provider)	16
304D – Modifier utilization issues (Provider)	17
304E – False coding (Provider)	18
304F – Price adjusting (Provider)	19
304G – Cost shifting (Provider)	20
306 – Using other provider TIN (Provider)	21
309 – Billing for unnecessary services (Provider)	22
310 – Profiles (Provider)	23
311 – Altering medical records (Provider)	24
312 – Duplicate charges (Provider)	25
314 – Experimental/investigational (Provider)	26
315 – PCO abuse (Provider)	27
316 – Fraudulent employee behavior (Provider)	28
317 – Practicing beyond scope of license (Provider)	29
318 – Overutilization (Provider)	30
319 – Balance billing (Provider)	31
320 – Federally excluded (Provider)	32
321 – Non-contracted/non-credentialed (Provider)	33
322 – Questionable claim (Provider)	34
323 – Re-audit (Provider)	35
399 – Miscellaneous not elsewhere specified (Provider)	36
401 – DME (Provider)	37
501 – Re-audit of claims from HRI, Concentra, etc. (Provider)	38
601 – Falsification enrollment application – Employer Group (Provider)	39
701 - Falsification enrollment application - Employee (Provider)	40
702 - Fraudulent Employee Behavior- Payer (Provider)	41
801 - Broker (Provider)	42
901 - Misuse of Corporate Credit Card (Provider)	43
902 - Misuse of Corporate Funds (Provider)	44

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Row Header	Row Number
903 - Forged check(s) - Unknown (Provider)	45
Total	46

Section IV: Member/Representative Investigations

Before entering data in the Report, ensure that the "Member/Representative Investigations" tab is selected. This section of the Report captures the number of preliminary investigations of Member/Representatives that have been referred to or identified by the MCO for incidents of suspected and/or confirmed fraud, waste, and abuse.

For each month of the reporting quarter, provide the number of Member/Representative fraud, waste, and abuse cases that were opened based on initial allegation codes provided in the Report. If a Member/Representative case fits more than one code, please select the most appropriate code.

Columns E/I/M/Q in the Report capture the quarterly total for each row outlined and will automatically sum; data entry is not required in these fields. Column R in the Report captures the year to date total for all measures and will automatically sum; data entry is not required in this field.

The following codes and descriptions are in the Member/Representative Investigations tab under column A in the Report and are as follows:

Row Header	Row Number
101 – Forgery of prescriptions (Member/Representative)	8
102 – Misuse of ID card (Member/Representative)	9
103 – Misuse of transportation (Member/Representative)	10
104 – Eligibility issues (Member/Representative)	11
105 – Forged checks (Member/Representative)	12
106 – Selling prescription drugs (Member/Representative)	13
107 – Reimbursement/TPL issues (Member/Representative)	14
109 – Falsification of enrollment application	15
110 – Overutilization (Member/Representative)	16
111 – Use of ID card by non-	17
112 – Misuse of service by parent or guardian	18
113 – Misuse of lodging (Member/Representative)	19
114 – Co-payment evasion (Member/Representative)	20
115 – Poly-pharmacy abuse/illicit drug seeking	21
116 – REOMBs feedback (Member/Representative)	22

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Row Header	Row Number
117 – Personal Care Services (or Options) Abuse	23
118 – Timesheet Falsification (Member/Representative)	24
119 – Collusion (Member/Representative)	25
199 – Miscellaneous not elsewhere specified (Member/Representative)	26
Total	27

Section V: Caregiver Investigations

Before entering data in the Report, ensure that the "Caregiver Investigations" tab is selected. This section of the Report captures the number of preliminary investigations of Caregivers that have been referred to or identified by the MCO for incidents of suspected and/or confirmed fraud, waste, and abuse.

For each month of the reporting quarter, provide the number of Caregiver fraud, waste, and abuse cases that were opened based on initial allegation codes provided in the Report. If a Caregiver case fits more than one code, please select the most appropriate code.

Columns E/I/M/Q in the Report capture the quarterly total for each row outlined and will automatically sum; data entry is not required in these fields. Column R in the Report captures the year to date total for all measures and will automatically sum; data entry is not required in this field.

The following codes and descriptions are in the Caregiver Investigations tab under column A in the Report and are as follows:

Row Header	Row Number
405 – Timesheet Falsification (Caregiver)	8
406 – Misuse of ID card (Caregiver)	9
407 – False Documentation (Caregiver)	10
408 – Abuse/Theft of Member/Representative's Prescriptions for Profit (Caregiver)	11
409 – Present on Admission/Paid Without Approved Exception Request (Caregiver)	12
410 – Not Rendering Service (Caregiver)	13
411 – Clocking In/Out Outside of Geographical Area (Caregiver)	14
412 – Fraudulent Behavior (Caregiver)	15
413 – Personal Care Option Abuse (Caregiver)	16
414 – Billing for Unnecessary Services (Caregiver)	17
415 – Collusion (Caregiver)	18
416 – Theft of Member/Representative's Property (Caregiver)	19

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Row Header	Row Number
499 – Miscellaneous not elsewhere specified (Caregiver)	20
Total	21

Section VI: Recoupment, Cost Avoidance, and Return on Investments

Before entering data in the Report, ensure that the "Recoup-CostAvoid-ROI" tab is selected. This section of the Report captures data on MCO recoupment, cost avoidance activities and Return on Investment (ROI) for the reporting quarter. Ensure this section of the Report is updated for the reporting quarter in order to collect cumulative data from the previous reporting quarters.

Column F in the Report captures the year to date total for all rows and will automatically sum; data entry is not required in this field.

Recoupment

This section of the Report captures the total amount in dollars recovered through the MCO's recoupment process for each quarter. The Row Headers listed below are in the Recoup-CostAvoid-ROI tab in the Report. A description for each Row Header is as follows:

Row Header	Row Number	Description
Amount Identified	7	The total amount in dollars that was identified as an overpayment for the reporting quarter as a result of an MCO Special Investigation Unit's (SIU's) investigation, audit, or review. This is the dollar amount identified as being overpaid and can be for either an open or closed case during the quarter. The amount identified for an open or closed case can only be captured one time during any reporting quarter or CY (i.e. amounts identified cannot be recaptured and added to the total each month, quarter, or year). Any increase or decrease identified after the identified overpayment is reported, which could be due to additional investigation, audit, or review work, the total identified overpayment for the reporting quarter must be adjusted for any difference due to the increase or decrease.
Amount Recovered	8	The dollar amount that was recovered that resulted from an investigation, audit, or review during the reporting quarter. This is the dollar amount actually recovered and can be for either an open or closed case during the quarter. The amount recovered for an open or closed case can only be captured one time during any reporting quarter or calendar year (i.e. amounts identified cannot be recaptured and added to the total each month, quarter, or year). The amount here will automatically populate in Row 17 (Amount

Row Header	Row Number	Description
		Recovered) in the Return on Investment section of the "Recoup-CostAvoid-ROI" tab in the Report.
Total Amount Pending	9	The dollar amount that remains outstanding at the end of the reporting quarter. This is the amount identified as being overpaid minus the amount recovered during the reporting quarter. The Report will automatically calculate; Data entry is not required in this field.

Cost Avoidance

This section of the worksheet captures the total dollar amount saved through cost avoidance activities during the reporting period.

Row Header	Row Number	Description
Cost Avoidance Amount	13	Enter the total dollar amount saved through Cost Avoidance (CA) activities as of the last day of the reporting quarter. The CA is the dollar amount that would have been paid to the Provider by the MCO had the Provider been allowed to continue to submit claims and is a result of a program integrity prepayment review or other claim specific to front-end edits as identified by the following denial code descriptions: 1. Assistant Surgeon not Covered 2. Service not Covered for Diagnosis 3. Inappropriate Billing 4. Claim Check/Bundling/All Inclusive 5. Invalid CPT/Modifier/HCPCS or Combination 6. Invalid Place of Service for Procedure 7. The diagnosis/Procedure is inappropriate for patient's age 8. Invalid Provider for Type of Procedure Indicated 9. Invalid Procedure for Patient's Gender 10. Adjusted-Incorrect Billing by Provider (this applies after the final determination is made that a provider has billed incorrectly) 11. Maximum Frequency for the Service has been met 12. Based on Review of Additional Information Submitted for Services, no Additional Consideration is Available

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Return on Investment

This section of the Report captures ROI for program integrity recoveries as they relate to the cost of the MCO's Special Investigation Unit (SIU).

Row Header	Row Number	Description
Amount Recovered	17	The total dollar amount recovered during the reporting quarter. This is the same amount identified in Row 8 (Amount Recovered) in the Recoupment section of the "Recoup-CostAvoid-ROI" tab in the Report. The Report will automatically self-populate this cell; Data entry is not required in this field.
SIU Costs	18	The total costs for the MCO's SIU for the reporting quarter. This includes employee salary and benefits, and/or the MCO's SIU vendor flat monthly fee.
Total ROI Recovered ($)	19	The Total ROI Recovered dollars calculation is the Amount Recovered (Row 17) minus the SIU's Costs (Row 18) for the reporting period. The Report will automatically calculate; Data entry is not required in this field.
Total ROI Recovered (%)	20	The Total ROI Recovered percentage calculation is the Amount Recovered (Row 17) divided by the SIU's Costs (Row 18) for the reporting quarter. The Report will automatically calculate; Data entry is not required in this field.

Section VII: Suspicious Activity

Before entering data in the Report, ensure that the "Suspicious Activity" tab is selected. This section of the Report captures detailed information on allegations received or identified by the MCO during the reporting quarter. This tab will capture open and closed investigations, audits, or reviews (cases) that have an indicator of suspicious activity.

Cases must remain on this Report for each reporting quarter until the case has either been closed by the MCO or officially referred to HSD-OIG due to a potential credible allegation of fraud. The section requires the MCO to indicate in Column A if the case was "carried over" from a previously reported quarter, or if the case was referred during the current reporting quarter.

This section of the Report is formatted to accommodate many entries and contains drop-down lists for several columns. **If additional rows are necessary, new rows must be inserted before the last row in the Report to ensure drop-down list functionality.** Not doing so will affect the data in other sections of the Report. Do not alter the formulas/data in these columns.

Column Header	Column	Description
Carried Over? (Y/N)	A	If the case remained unresolved (open) at the end of the previously reported quarter, select Yes (Y) for "Carried

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Column Header	Column	Description
		Over". If the case was referred during the current reporting quarter, select No (N) for not "Carried Over". If the case becomes a No, for example, because it will not be referred, i.e. not substantiated, during the reporting quarter, it should still be listed on the Report for the reporting quarter. After which, only the No cases can be removed from all following reporting quarters.
MCO Internal Case Number	B	The MCO's internal identification number for the case.
Date Received by MCO	C	The date (M/D/YYYY) the allegation(s) was received by the MCO (This is not the date the MCO confirmed the suspicious activity).
Date Reported to HSD-OIG	D	The date (M/D/YYYY) the allegation(s) was reported to HSD/OIG. If the suspicious activity has not yet been reported to HSD-OIG, enter "ND."
Case Type	E	The type of case. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). **Provider** – Indicates a Provider is the subject. **Member/Representative** – Indicates a Member/Representative is the subject. **Caregiver** – Indicates a Caregiver is the subject. **Agent/Broker** – Indicates a sales entity (i.e., SCI enrollment broker) is the subject.
Case Name	F	List the case subject name in accordance with the Case Type. For example: If Case Type is a Member/Representative, the Case Name should be the Member/Representative's name. If the case involves more than one Member/Representative, list all Member/Representative names separated with a semi-colon (the cell will wrap the text).
Referral Source	G	The referral source of the allegation(s) (who referred the allegations to the MCO). Please select from the dropdown list (a dropdown arrow will show when the cell is selected). **AGO/MFCU** – New Mexico Office of Attorney General, Medicaid Fraud Control Unit. **Anonymous** – An unknown or confidential referral source. **DEA** – Drug Enforcement Agency. **Dental Subcontractor** – an MCO subcontractor that provides dental services. **OSI/IS** – NM Office of Superintendent of Insurance, Investigations Section. **FBI** – Federal Bureau of Investigation.

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Column Header	Column	Description
		HSD/OIG – New Mexico Human Services Department, Office of Inspector General. **HSD** – New Mexico Human Services Department; all other HSD bureaus, except OIG. **IRS** - Internal Revenue Service. **MCO Associate** – a program integrity complaint, tip or lead provided from a source within the MCO/Plan operations/departments. This also includes a program integrity complaint, tip or lead generated from the MCO's periodic review of Member/Representative utilization of benefits. **Member/Representative/Caregiver** – a program integrity complaint, tip or lead from an MCO Member/Representative or Caregiver. **NMMB** – New Mexico Medical Board. **NMBP** – New Mexico Board of Pharmacy. **NMTRD** – the New Mexico Taxation and Revenue Department. **NMWCA** – New Mexico Workers Compensation Administration. **Other** – a program integrity complaint, tip or lead from another source not described in this list, i.e., media, other MCO, Law Enforcement, etc. **Provider** – a program integrity complaint, tip or lead from a direct Provider, i.e., Medical Doctor, Doctor of Osteopathic Medicine, Nurse Practitioner, Dentist, Pharmacist, Behavioral Health Provider/Therapist, etc., or Home Health, Private Coverage Option, Durable Medical Equipment, or health care facilities, i.e., hospital, Residential Treatment Center, Skilled Nursing Facility, Nursing Facility, etc. **Provider Employee** – a program integrity complaint tip or lead provided from a Provider's employee. Note, list "Provider Employee" only if it is an employee of the same Provider that is already identified in the Case Type and Case Name fields. If the referral is from a different Provider than list "Other". **Provider Profiling/Data Mining** – a program integrity complaint, tip or lead identified from aberrant utilization or prospective and retrospective data mining. **Sanctions & Exclusions Monitoring** – a program integrity complaint, tip or lead generated from the

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Column Header	Column	Description
		identification of a sanctioned or excluded Provider. **Transportation Subcontractor** – an MCO subcontractor that provides transportation services. **Vision Subcontractor** – an MCO subcontractor that provides vision services.
Initial Allegation Code	H	The initial allegation code to describe the allegation(s) under review. More than one code may apply, select the most appropriate code. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). **Provider Initial Allegation Codes** **205** – Audit claims (Provider) **210** – Intentionally left blank **301** – Use of unlicensed staff (Provider) **302** – Kickbacks (Provider) **303** – Billing for services not rendered (Provider) **304** – Up-coding/Unbundling issues (Provider) **304A** – Unbundled charges (Provider) **304B** – Upcoded charges (Provider) **304C** – Split billing/serial billing (Provider) **304D** – Modifier utilization issues (Provider) **304E** – False coding (Provider) **304F** – Price adjusting (Provider) **304G** – Cost shifting (Provider) **306** – Using other provider TIN (Provider) **309** – Billing for unnecessary services (Provider) **310** – Profiles (Provider) **311** – Altering medical records (Provider) **312** – Duplicate charges (Provider) **314** – Experimental/investigational (Provider) **315** – PCO abuse (Provider) **316** – Fraudulent employee behavior (Provider) **317** – Practicing beyond scope of license (Provider) **318** – Overutilization (Provider) **319** – Balance billing (Provider) **320** – Federally excluded (Provider) **321** – Non-contracted/non-credentialed (Provider) **322** – Questionable claim (Provider) **323** – Re-audit (Provider) **399** – Miscellaneous not elsewhere specified (Provider) – Please describe in Analysis question #3.

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Column Header	Column	Description
		Other Initial Allegation Codes **401** – DME (Provider) **501** – Re-audit of claims from HRI, Concentra, etc. (Provider) **601** – Falsification enrollment application – Employer Group (Provider) **701** – Falsification enrollment application – Employee (Provider) **702** – Fraudulent Employee Behavior – Payer (Provider) **801** – Broker (Provider) **901** – Misuse of corporate credit card (Provider) **902** – Misuse of corporate funds (Provider) **903** – Forged check(s) – Unknown (Provider) **Member/Representative Initial Allegation Codes** **101** – Forgery of prescriptions (Member/Representative) **102** – Misuse of ID card (Member/Representative) **103** – Misuse of transportation (Member/Representative) **104** – Eligibility issues (Member/Representative) **105** – Forged checks (Member/Representative) **106** – Selling prescription drugs (Member/Representative) **107** – Reimbursement/TPL issues (Member/Representative) **109** – Falsification enrollment application (Member/Representative) **110** – Overutilization (Member/Representative) **111** – Use of ID card by non-Member/Representative/impersonation (Member/Representative) **112** – Misuse of service by parent or guardian (Member/Representative) **113** – Misuse of lodging (Member/Representative) **114** – Co-payment evasion (Member/Representative) **115** – Poly-pharmacy abuse/illicit drug seeking (Member/Representative) **116** – REOMBs feedback (Member/Representative) **117** – Personal Care Services Abuse **118** – Timesheet Falsification **119** – Collusion **199** – Miscellaneous not elsewhere specified (Member/Representative) – Please describe in Analysis question #4. **Caregiver Initial Allegation Codes** **405** – Timesheet Falsification (Caregiver) **406** – Misuse of ID card (Caregiver)

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Column Header	Column	Description
		407 – False Documentation (Caregiver) **408** – Abuse/Theft of Member/Representative's Prescriptions for Profit (Caregiver) **409** – Present on Admission/Paid Without Approved Exception Request (Caregiver) **410** – Not Rendering Service (Caregiver) **411** – Clocking In/Out Outside of Geographical Area (Caregiver) **412** – Fraudulent Behavior (Caregiver) **413** – Personal Care Option Abuse (Caregiver) **414** – Billing for Unnecessary Services (Caregiver) **415** – Collusion (Caregiver) **416** – Theft of Member/Representative's Property (Caregiver) **499** – Miscellaneous not elsewhere specified (Caregiver) – Please describe in Analysis question #5.
Geographical Area	I	Identify the county in New Mexico. If the suspicious activity occurs outside of New Mexico, please use "N/A".
Case Status	J	The status of the case as of the last day of the reporting quarter. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). **Pending** – a preliminary review and/or open investigation in process. **Closed Internally** – investigation completed with or without finding(s) or no overpayment is identified. **Closed and Referral to HSD/OIG** – MCO referred matter to HSD/OIG. The HSD/OIG will handle all referrals as appropriate.
Final Disposition Code	K	The final disposition code for the case. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). Note: If the case is pending and has not reached a final disposition, select "**Pending**" from the dropdown list. **A** – Altering of records **AG** – Agree with external audit findings **B** – Billing error **B1** – Balance billing **C01** – Billing for unnecessary services **C1** – Conspiracy **C2** – Collusion **COPA** – Co-payment evasion **D01** – Overutilization

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Column Header	Column	Description
		DG – Disagree with external audit findings **DME** – Misuse of DME **E01** – Application falsification **F** – Forged check(s) **F01** – Fee For Service **FEP** – Federally excluded **G** – Does not understand plan benefits **H** – Not covered by CMS or plan benefits **I01** – Under review by external agency **I02** – Under review – Personal Care Services **IDTH** – Identity theft **IPOS** – Inappropriate place of service (location code) billed **J** – Forgery of prescriptions **J01** – Drug seeking **J01A** – Poly pharmacy abuse/illicit drug seeking **J01B** – Referred to care coordination for PCP/Pharmacy lock-in **K** – Misuse of ID card **K01** – Misuse of ID card by non-Member/Representative/impersonation **L** – Misuse of transportation **M** – Misuse of lodging NF – No findings or overpayment identified **NC** – Non-contracted/Non-credentialed **O** – Allegation not confirmed **P** – Use of unlicensed staff **P02** – Billing for services beyond scope of license **Q** – Kickbacks **QC** – Questionable claim **R** – Billing for services not rendered **R01** – Payment error by plan **RA** – Re-audit **S** – Up coding/Unbundling issues **S1** – Unbundled charges **S2** – Upcoded charges **S3** – Split billing/serial billing **S4** – Modifier utilization issues **S5** – False coding **S6** – Price adjusting **S7** – Cost shifting **T01** – TIN issue **TF** – Timesheet falsification **U** – Contractual/LOA/Configuration **W** – Not administered by plan **X** – Experimental/investigational

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Column Header	Column	Description
		Y – Forgery (not checks) **Z4** – Federal excluded/sanctioned/suspended/debarred – individual, entity, Provider **ZZ** – Referred to legal department **ZZZ** – Verdict guilty – Federal debarment
Closure Date	L	The date (M/D/YYYY) the case is closed. The closure date occurs when the case is closed without a finding(s), or when the case is referred to HSD/OIG, whichever is later.
Overpayment Identified	M	The status of an overpayment identified as a result of the case investigation. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). **Yes** – the case status is closed with an overpayment identified within the reporting period. There is an identified overpayment after the Provider, Member/Representative, or Caregiver has exhausted their appeal and/or mediation rights, if applicable. **No** – the case status is closed or referred with no overpayment identified within the reporting period. **Pending** – the case status is pending under a preliminary review and/or open investigation is in process. An overpayment is yet to be determined.

Section VIII: Adverse Actions

Before entering data in the Report, ensure that the "Adverse Actions" tab is selected. This section of the Report captures detailed information on adverse actions (see the definition above) taken on provider applications for participation in the Medicaid program. The MCO is required to notify the HSD/OIG and HSD Medical Assistance Division, Provider Enrollment (MAD/PE), of adverse actions within 5 business days via email of a final decision. Examples of conduct that would constitute adverse action include, but are not limited to:

- Providers that are denied enrollment or terminated as a result of adverse licensure actions, e.g., providers who are reported to the Medicare Exclusion Database (MED), Department of Health and Human Services/OIG General List of Excluded Individual Entities (LEIE);
- Providers that are denied enrollment or terminated due to the engagement of fraudulent conduct;
- Providers that are denied enrollment or terminated due to abuse of billing privileges, e.g. billing for services not rendered or unnecessary medical services;
- Providers that are denied enrollment or terminated due to misuse of their Medicaid provider billing number;
- Providers that are denied enrollment or terminated due to falsification of information on enrollment application or information submitted to maintain enrollment;
- Providers that are denied enrollment or terminated due to continued billing after suspension or revocation of the provider's professional licensure or certification;

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- Providers that are denied enrollment or terminated based on a State and/or Federal exclusion;
- Providers that are denied enrollment or terminated due to falsification of medical records which support services billed to Medicaid.

Cases must remain on the Report for each reporting quarter until the case has been closed by the MCO **and** the OIG has acknowledged receipt of the adverse action. This section requires the MCO to indicate in Column A of the Report whether the case was "Carried Over" from a previous reporting quarter or if the case was received during the current reporting quarter.

This section of the Report is formatted to accommodate many entries and contains drop-down lists for several columns. **If additional rows are necessary, new rows must be inserted before the last row in the Report to ensure drop-down list functionality.** Not doing so will affect the data in other sections of the report. Please do not alter the formulas/data in these columns.

Column Header	Column	Description
Carried Over? (Y/N)	A	If the case remained unresolved (open) at the end of the previously reported quarter, select "Yes" for Carried Over. If the case was received during the current reporting quarter, select "No".
Date of Adverse Action	B	The date (M/D/YYYY) of the adverse action (final decision).
Date OIG Acknowledged Receipt of MCO Notification	C	The date (M/D/YYYY) the OIG acknowledged receipt of the MCO's notification of the adverse action.
Provider Name	D	The name of the Provider.
Provider NPI	E	The NPI number of the Provider.
Provider Specialty	F	The specialty type of the Provider.
Termination Reason	G	The reason for termination as defined by MAD/PE when the MCO denied or terminated a Provider application. Please select from the dropdown list (a dropdown arrow will show when the cell is selected). For termination reasons that would be classified as "other", provide a description for termination in the "Analysis" tab of the Report. 1. Adverse licensure actions (e.g., registered in the National Practitioner Data Bank). 2. Engaged in fraudulent conduct. 3. Abuse of billing privileges for services not rendered or for medically unnecessary services. 4. Misuse of their billing number. 5. Falsification of information on enrollment application or information submitted to maintain enrollment. 6. Continued billing after suspension or revocation of Provider's medical license. 7. State and/or Federal exclusion. 8. Falsification of medical records which support services billed to Medicaid. 9. Quality of care issue.

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Column Header	Column	Description
		10. Other with a description in the “Analysis” tab of the Report.