OVERVIEW

Intentional Program Violation (IPV) occurs when the client, provider and/or client's authorized representative intentionally make a false or misleading statement, hides or misrepresents/withholds facts to receive or to continue receiving benefits. IPV is considered fraud and must be reported to the Office of Inspector General.

Client Suspected of Intentional Program Violation (IPV)

Suspected intentional program violation (IPV) means an overpayment exists when all three of the following conditions occur:

- The client (or legally responsible party) intentionally failed to report information or gave incomplete or inaccurate information needed to make a correct benefit determination.
- The client was clearly instructed regarding his or her reporting responsibilities to the Department.
  
  Note: A signed DHS-390, Adult Services Application instructs the client of their reporting responsibilities. The specialist must reiterate the client's responsibility to report any changes within 10 business days during the client case reviews.
- The client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill their reporting responsibilities.

Intentional program violation (IPV) is suspected when there is credible evidence that the client has intentionally withheld or misrepresented information for the purpose of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility. In such cases where these conditions exist, make a fraud referral to the Office of Inspector General (OIG).

Example: The client (or legally responsible party) intentionally reports inaccurate or incomplete information to conduct an accurate comprehensive assessment of need for home help.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.
Providers Suspected of Intentional Program Violation (IPV)

A suspected provider intentional program violation (IPV) is an overpayment caused by a provider's intentional false billings or intentional inaccurate statements. Examples of provider overpayment that may be an IPV are:

- Failing to bill correctly (intentionally submitting an incorrect invoice).
- Receiving payment for hours when the client was unavailable; such as but not limited to hospitalizations, nursing home or AFC stays.
- Receiving payment for hours when the provider was unavailable and/or did not provide the care.

Example: Provider receives and cashes a single party warrant for a time period he or she is unavailable and did not provide care.

Intentional program violation is suspected when there is credible evidence that the provider has intentionally withheld or misrepresented information for the purpose of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.

OIG REFERRAL CRITERIA

When an adult services specialist believes fraud has occurred within the home help program, the specialist must make a referral to the Office of Inspector General (OIG). Prudent judgement should be used in evaluating an overpayment for suspected IPV.

Consider the following questions when reviewing the case for fraud:

- Does the case record indicate department staff advised the client of his or her rights and responsibilities?
Note: The DHS-390 instructs clients of their rights and responsibilities; however the specialist must remind the client and provider of his or her reporting responsibilities at each case review.

- Does the case narrative reflect the client's acknowledgement of these rights and responsibilities?
- Did the client or provider neglect to report timely when required to do so after being informed of their responsibility to report?
- Did the client or provider make false or misleading statements?
- Does the client or provider error meet suspected IPV criteria?

Home Help Fraud/IPV Scenarios

The following scenarios are provided as guidance for when a home help fraud referral should be made to the Office of Inspector General:

- Client alters or forges the DHS-54A, Medical Needs form in order to become eligible for services.
- Client forges the provider's signature on a dual-party warrant and services were not provided.

Note: If the client forges the provider's signature on a dual-party warrant and services were provided, this becomes a civil matter and should not be referred to OIG.

- Client/provider has an arrangement to split the warrant and services were not provided.
- Provider reports earnings indicated on his/her W-2 are inaccurate and the specialist discovers services were not provided.

Example: Provider asserts he or she ended services on a specific date but the warrants continued to be cashed under their name.

- Client fails to disclose changes that would affect their eligibility or cost of care and was clearly instructed regarding their reporting responsibilities.
Example: Client gets married and the spouse is able and available to provide care.

Example: Client’s health improves and they fail to report the change in care needs.

Example: Client fails to disclose others living in the home which would affect their proration for instrumental activities of daily living (IADL).

- The provider cashes the warrant when the client was unavailable.

Example: Client was admitted into a nursing facility and the provider continued to cash the warrant(s).

- The provider continues to receive and cash warrants after the client’s death.

If the specialist questions the appropriateness of a referral, it should be forwarded to OIG who will determine whether to investigate.

Making a Referral to OIG

Refer all suspected cases of fraud/IPV in the home help program to OIG using the DHS-1131, Medicaid Services Fraud Intake Form. This form must be used in lieu of the DHS-834, Fraud Investigation Request. Complete the DHS-1131 and provide copies of all supporting documentation that would assist in the investigation.

Scan and send the DHS-1131 and supporting documentation to the OIG Fraud Complaint mailbox at:

MDHHS-OIG-InvestigativeSupport@michigan.gov

The adult services specialist will be notified if a referral is denied for investigation.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted.

Threshold

Provider fraud has no threshold and should be reported to OIG. A provider IPV overpayment of $500 or greater is a felony.
Client suspected IPV has a threshold of $500. A referral to OIG must be made if the total overpayment is less than $500, and one of the following conditions exists:

- The client has a previous IPV, or
- The client has had at least two client errors previously, or
- The alleged fraud is committed by a state government employee.

If the overpayment is less than $500 and doesn't meet the conditions above, refer to ASM 165, Overpayment and Recoupment Process.

**OIG RESPONSIBILITIES**

The MDHHS Office of Inspector General is the sole contact point for all fraud referrals pertaining to home help and the investigation will be assigned based on the investigation type (client or provider).

Referrals are made to the Attorney General Medicaid Healthcare Fraud Division for prosecution when there is credible evidence of fraud that exceeds $4000.

**Action Taken by OIG**

Within 12 months OIG will:

- Refer suspected IPV cases that meet criteria for prosecution to the prosecuting attorney or AG's office.
- Refer suspected IPV cases that meet criteria for IPV administrative hearings to the Michigan Administrative Hearings System (MAHS).
- Return all non-IPV client cases to the adult services specialist to initiate recoupment.
- Pursue recoupment for non-IPV provider cases. A Recoupment Letter is sent to the provider with a copy to MDHHS Medicaid Collections Unit and the adult services specialist. **No further action is required by the adult services specialist.**

**Note:** OIG will not send a copy of the recoupment letter to the local county MDHHS office if the case is closed.
IPV Hearings

OIG shall request an IPV hearing when there is no signed DHS-4350, Intentional Program Violation Repayment Agreement obtained and correspondence to the client is returned as undeliverable, or a new address is located.

The department may request a hearing to:

- Establish an intentional program violation against the client.
- Establish a collectable debt (client debt).

HOME HELP PROVIDER SUSPENSION

Pursuant to federal law, codified at 42 CFR 455.23, a state Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual provider or entity, unless there is good cause not to suspend.

The MDHHS OIG will notify the adult services program office when a credible allegation of fraud is evident against a home help provider. The AS Program Office will contact the local MDHHS office and instruct the specialist to suspend the payment authorization(s). The MDHHS Provider Enrollment unit will be notified to end date/suspend the provider eligibility in CHAMPS. OIG will inform the local office and the program office if the provider suspension is lifted.

RECOUPEMENT

No recoupment action should be taken on cases that are referred to OIG for investigation until notified.

OIG will notify the referring adult services specialist of non-IPV substantiated cases of client fraud. The specialist will be responsible for initiating the recoupment.

OIG will initiate recoupment on provider fraud cases investigated but denied for prosecution. OIG will send the provider a recoupment letter and forward a copy to the MDHHS Medicaid Collection unit for recoupment. No further action is needed by the adult services specialist.
The Office of Inspector General established the Front End Eligibility (FEE) program in response to the need for fraud prevention. The goal of the FEE program is to obtain and maintain a partnership between the MDHHS local office staff early in the eligibility determination process in order to reduce errors.

**FEE Referral**

The adult services specialist may request a pre-eligibility investigation by the OIG regulation agent when it is believed the client is intentionally misrepresenting the need for home help. Referrals for FEE are also accepted for open cases when it is believed a client is misrepresenting the need for continued care.

Examples of an appropriate FEE referral for home help would be the following:

- A home help case is denied due to a spouse (responsible relative who is able and available) in the home and client later reapplies claiming the spouse has moved out of the home.

- The specialist suspects the client and provider of home help are married to one another and they are not disclosing their marital status.

- The client indicates he or she lives alone either verbally or on the DHS-390, Adult Services Application but Bridges shows others living in the home.

- Client’s medical condition improves and fewer services are needed but the client/provider fails to report.

**Components of a Quality FEE Referral**

The following are components of a quality FEE referral:

- The case should be active or pending for benefits.
- Ensure that policy supports why the client may not be eligible.
- Provide accurate case demographics.
- Attach all supporting documentation.

To make a FEE referral, select the hyper link which states Front End Eligibility (FEE) Referral Form on the MDHHS-Net under Hot Topics.
OIG regulation agents must complete the investigation within ten business days and respond to staff with their findings. Investigations are completed prior to opening the case or recertifying the applicant for benefits.