MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

# GEORGIA DEPARTMENT OF COMMUNITY HEALTH

## GEORGIA FAMILIES

### STATE FISCAL YEAR 2013

### REPORT #24: FRAUD AND ABUSE REPORT MONITORING ANALYSIS

**FINAL: June 9, 2014**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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# *Glossary*

The following listing of terms and references are used throughout our description of procedures and findings:

- **Abuse** – Practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary costs to Medicaid or reimbursement for services that are not medically necessary or that fail to meet professional standards or contractual obligations for health care. It also includes Member and P4HB Participant practices that result in unnecessary cost to the Medicaid program.

- **Avesis** – Avesis is subcontracted with WellCare of Georgia to administer the provision of vision care services to Georgia Families members.

- **Care Management Organization (CMO)** – An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids® members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member. Three Care Management Organizations currently operate in Georgia. These organizations include Amerigroup (AGP), Peach State Health Plan (PSHP), and WellCare of Georgia (WellCare).

- **Caremark** – CVS Caremark is subcontracted with Amerigroup to administer pharmacy benefit management services to Georgia Families members.

- **Cenpatico Behavioral Health, LLC® (Cenpatico® or CBH)** – Cenpatico, a wholly owned subsidiary of Centene Corporation, is subcontracted with Peach State Health Plan to administer behavioral health benefit management services to Georgia Families members.

- **Coding Validation Initiative (CVI)** – A team of individuals within the Premium and Medical Claims Integrity department at Amerigroup that identify aberrant provider billing practices and attempt to modify provider behavior through education.

- **Complaint/Referral –** The cause or reason for an alleged act such as provider, member, or vendor misuse of Medicaid services which may result in a fraud or abuse claim.

- **Corporate Investigations Department (CID Intel)** – The Department within Amerigroup that concentrates its efforts on the investigation of allegations of fraud, waste, and abuse.

- **DentaQuest** – DentaQuest is subcontracted with Amerigroup, Peach State Health Plan, and WellCare of Georgia to administer dental benefit management services to Georgia Families members.

- **Department of Community Health (DCH or Department)** – The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids® programs.

- **Fraud** – An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

- **Fraud and Abuse Report** – Each CMO is required to submit to DCH a monthly Fraud and Abuse Report which includes the following: source of complaint; alleged persons or entities involved; nature of complaint; dollars involved; date of the complaint; disciplinary action imposed; administrative disposition of the case; investigative activities, corrective actions, prevention efforts, and results; trending and analysis as it applies to: utilization management; claims management; post-processing review of claims; and provider profiling. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended.

- **Georgia Families –** The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with Care Management Organizations to manage and finance the care of eligible members.

- **Health Care Economics (HCE)** - HCE is utilized by Amerigroup as a complaint/referral source that comes from a Health Care Economics analyst.

- **Magellan** – Magellan is subcontracted with WellCare of Georgia to administer the provision of behavioral and mental health care services to Georgia Families members.

- **Medicaid Fraud Control Unit (MFCU)** – The Medicaid Fraud Control Unit investigates and prosecutes Medicaid fraud, as well as, patient abuse and neglect in Georgia health care facilities.

- **MEDIC** – MEDIC is utilized by WellCare of Georgia as a complaint/referral source that comes from Health Integrity the Medicare Part C and Part D program integrity contractor for the Centers for Medicare & Medicaid Services (CMS).

- **National Imaging Associates (NIA) –** National Imaging Associates is subcontracted with Peach State Health Plan to administer the provision of a radiology benefit management program to Georgia Families members.

- **National Health Care Anti-Fraud Association Special Investigation Resource and Intelligence System (NHCAA and SIRIS) -** NHCAA and SIRIS is utilized by WellCare of Georgia as a complaint/referral source. It refers to a referral generated by NHCAA members with SIRIS access which is designed to allow members to share critical information about fraud and abuse cases.

- **OptiCare** – OptiCare is subcontracted with Peach State Health Plan to provide routine vision and limited medical care services for Georgia Families members.

- **Referral Source** – Any party responsible for the referral or the receipt of a referral regarding allegations of potential fraud and abuse.

- **Scion Dental** – Scion is subcontracted with Amerigroup to provide dental benefit management services for Georgia Families members.

- **Special Investigations Unit (SIU)** – The unit operated by Peach State Health Plan's management company, Centene Corporation, that mines claims data for upcoding, unbundling, and other systematic deviations that suggest fraudulent or abusive billing practices and investigates all reports of waste, fraud, and abuse.

- **Subcontractor** – Any third party who has a written contract with a CMO to perform a specified part of the CMO's obligations under their DCH contract.

- **SVC Verification Letter** – the WellCare of Georgia equivalent to a Medicaid Explanation of Benefits (EOB) received by the member and used as a source of the complaint when the SIU hotline receives a call from a GA member regarding the Service Verification Letter.

- **Therapy Review Systems, Inc. (TRS**) – Therapy Review Systems, Inc. is subcontracted with Peach State Health Plan to provide occupational, physical and speech therapy benefit management services for Georgia Families members.

# *Project Background*

Myers and Stauffer was engaged to assist the Department of Community Health (DCH or the Department) in its efforts to assess the policies and procedures of the Georgia Families program. Previously issued reports are available online at http://dch.georgia.gov. These reports assessed payment and denial trends of hospital, dental, and physician claims, the payment accuracy of other selected claim types, and certain Care Management Organization (CMO) policies and procedures.

The Department directed and authorized Myers and Stauffer to analyze the Fraud and Abuse reports for all CMOs. The objective of this task was to evaluate the monthly Fraud and Abuse reports submitted by the CMOs and report any findings, as well as, give applicable recommendations as to any revisions to the report that could enhance the value to the Department.

We understand that each CMO is required to attest to and warrant that data and other information they provide to DCH is accurate, complete, and truthful, and is consistent with the ethics statements and policies of DCH. Therefore, in consultation with DCH, other than as described in the following sections, we did not perform specific procedures to confirm or validate the reported possible incidences of fraud and abuse.

# *Methodology*

Below we provide a description of the analysis performed, including a comprehensive list of the data and documentation utilized.

Each month, the CMOs are required to submit to the Department a Fraud and Abuse report. This report is in the form of a spreadsheet document which should contain the following information: source of complaint; alleged persons or entities involved; nature of complaint; approximate dollars involved; date of the complaint; disciplinary action imposed; administrative disposition of the case; investigative activities, corrective actions, prevention efforts, and results; trending and analysis as it applies to: utilization management; claims management; post-processing review of claims; and provider profiling.

The reports for Amerigroup (AGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare) were obtained by accessing each CMO's web portal. Myers and Stauffer evaluated the Fraud and Abuse reports for January 2012 through November 2012. Data from the Fraud and Abuse reports was combined, removing duplicate case numbers and entries, then evaluated in an effort to achieve the following:

- Obtain each CMO's Fraud and Abuse monthly report and review to ensure the reporting of required information;
- Identify potential fraud and abuse cases and issues currently captured in reports;
- Determine usefulness of the information being reported;
- Assess the effectiveness of the current reporting and tracking processes;
- Identify data required for effective fraud and abuse reporting.

A comparative analysis was also performed between the January 2012 through October 2012 Fraud and Abuse report samples against the November 2012 Fraud and Abuse report sample for each CMO. The November 2012 report was used as the final basis for this analysis.

Based on the results of our evaluation, Myers and Stauffer created, with DCH approval, a Fraud and Abuse Reporting Performance Metrics to track and report fraud and abuse cases and recoveries more effectively and accurately. The Fraud and Abuse Reporting Performance Metrics can be found in Exhibit 4.

# *Assumptions and Limitations*

The assumptions and limitations summarized below should be noted when reviewing this report.

- The data provided by the CMOs is presumed to be complete and accurate based on the attestation from each CMO.
- This analysis does not include a review of the CMO's compliance plan purposed to guard against Fraud and Abuse.
- This analysis does not include a review of CMO policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse.
- Dollar values reported by each CMO were assumed to be an estimated amount.
- We noted that many cases or leads had missing or zero values in the "approximate dollars involved" field on the Fraud and Abuse Report. Therefore, we could not accurately assess the financial impact of the reported fraud and abuse cases.
- We also noted "open" cases or leads that were listed on the January 2012 through October 2012 reports were missing when compared to the November 2012 report. These cases did not appear to have a final status.
- The subcontractors, who reported fraud and abuse cases, were contracted with their respective CMOs during the period of this report.
- Myers and Stauffer, for the purposes of this analysis, created Tables 1 through 9 and Exhibits 1 through 3 in order to summarize the data submitted by the CMOs. The actual CMO Fraud and Abuse reports are available to DCH upon their request.
- Effective January 1, 2013, the frequency of the Fraud and Abuse reports that the CMOs submit to DCH changed from monthly to quarterly.

# *Findings Summary*

Data for this analysis was collected from each CMO's Fraud and Abuse reports for January 2012 through November 2012. All fraud and abuse cases or leads reported by each CMO and its subcontractors were included in this analysis. Table I illustrates a summary of the fraud and abuse referral sources, case numbers, and dollars involved as reported by each CMO and its subcontractors to DCH during the analysis period. For the additional information regarding this analysis, please refer to Exhibits 1-3.

**AMERIGROUP**

Amerigroup and its subcontractors (Caremark [Pharmacy Benefit Manager], DentaQuest/Doral [Dental], and Scion [Vision]) reported 143 cases of potential fraud and abuse. The dollars involved in these cases were $30,896,826.49.

During the analysis period, for Amerigroup, the primary referral source of potential fraud and abuse complaints was AGP's own associates (internal referrals) with 42 cases. CID Intel referrals were the next highest referral source of complaints with 25 cases. Caremark, Dentaquest, and Scion, all subcontractors, accounted for 16 cases received. See Table 1 for a detailed listing of cases received by referral source.

**Table 1: CMO Case Referral Summary for 1/1/12 through 11/30/12 Referred From:**

| Referral Source | Cases Received | Dollars Involved* |
|---|---|---|
| **AGP** | | |
| AGP Associates | **42** | **$13,289,247.37** |
| CID Intel | **25** | **$12,570,231.18** |
| Member/ Parent / Guardian | **23** | **$1,064,538.77** |
| DCH | **10** | **$2,033,807.82** |
| Provider/Office Staff | **10** | **$421,866.60** |
| Concerned Citizens | **5** | **$501,510.66** |
| HCE | **4** | **$128,900.91** |
| CVI | **3** | **$94,194.00** |
| Anonymous Callers | **2** | **$142.55** |
| Federal Agency | **1** | **$112,574.67** |
| Law Enforcement | **1** | **$150.93** |
| Vendor | **1** | **$80,596.80** |
| **Caremark** | | |
| Caremark | **4** | **$339,871.89** |
| **DentaQuest** | | |
| CID Intel | **1** | **$28,844.34** |
| **Scion** | | |
| CID Intel | **7** | **$0.00** |
| Vendor | **4** | **$230,348.00** |
| **Grand Total** | **143** | **$30,896,826.49** |

**Amount represents estimated dollars as reported by each CMO.*

The following is a list of the top five member/provider types for potential fraud and abuse during the analysis period, ranked by the most to the least number of cases (Table 2).

**Table 2: Amerigroup's Top Five Types of Potential Fraud and Abuse**

| Member/Provider Type | Number of Cases |
|---|---|
| Member | 19 |
| Licensed Professional Counselor | 14 |
| Pediatrics | 12 |
| Obstetrics / Gynecology | 11 |
| Family Practice | 7 |

Of the top five potential fraud and abuse complaints, overutilization-excessive service, billing contract limit was most commonly referred with 42 cases. Table 3 lists the top five complaints reported by AGP and its subcontractors during the analysis period, ranked by the most to the least number of cases.

**Table 3: Amerigroup's Top Five Potential Fraud and Abuse Complaints**

| Potential Fraud or Abuse | Number of Cases |
|---|---|
| Overutilization-excessive services, billing contract limit | 42 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 22 |
| Upcoding the level of service provided | 13 |
| Provider over prescribing/prescription fraud | 9 |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 8 |

### Disposition of Cases

As of the November 2012 report, Amerigroup and its subcontractors reported a total of 59 open cases accounting for $22,613,586.70. Of the 59 open cases, 16 cases exceed 365 days from the date the case or lead was entered on the report. The dollars involved in these cases were $6,087,601.29.

Of the 143 reported cases, Amerigroup closed 56 cases accounting for $5,780,645.19 during the analysis period. Collectively, Amerigroup's subcontractors closed five cases which accounted for $214,992.34. Myers and Stauffer was unable to clearly document the total number of recoupments or recoveries associated with these cases.

During the analysis period, there were 23 open cases or leads for Amerigroup and Caremark that did not appear on the November 2012 report. The dollars involved in these cases were $2,108,086.26. For these cases, Myers and Stauffer expected the CMO to indicate a disposition of "Closed", "Cleared", "Inactive", or "Referred" on a case or lead prior to removing it from a monthly report.

## Additional AGP Findings

- Amerigroup referred 13% of the reported cases to the Department of Community Health Office of Inspector General, the Medicaid Fraud Control Unit, or another agency.
- The average time to close a case is 724 days by Amerigroup and/or its subcontractors.

- AGP provided amounts in the "approximate dollars involved" field for their reported cases more frequently than PSHP and WellCare.
- In some cases, we noted that zero dollar values were entered as dollars involved on the Fraud and Abuse monthly reports.
- The existing Fraud and Abuse report template lacked an efficient means of reporting pertinent information such as accurate accounting for cases opened and closed, tracking of pending and referred cases, and total dollars recouped and recovered.

## PEACH STATE HEALTH PLAN

Peach State Health Plan and its subcontractors (CBH-Cenpatico Behavioral Health [Behavioral Health], DentaQuest [Dental], NIA- National Imaging Associates [Radiology Benefit Management], OptiCare [Vision], and TRS-Therapy Review System [Therapy]) reported 134 cases of potential fraud and abuse. The dollars involved in these cases were $2,221,467.77.

During the analysis period, for Peach State Health Plan, the primary referral source of potential fraud and abuse complaints was PSHP's own Special Investigations Unit (SIU) which totaled 19 cases. PSHP internal referrals were the next highest referral source of complaints with 16 cases. CBH, DentaQuest, NIA, OptiCare, and TRS, all subcontractors, accounted for 38 cases received. See Table 4 for a detailed listing of cases received by referral source.

**Table 4: CMO Case Referral Summary for 1/1/12 through 11/30/12 Referred From:**

| Referral Source | Cases Received | Dollars Involved* |
|---|---|---|
| **PSHP** | | |
| SIU | **19** | **$728,005.87** |
| PSHP | **16** | **$1,328,770.52** |
| Provider/Office Staff | **4** | **$121,407.00** |
| DCH | **4** | **$0.00** |
| Compliance Line | **3** | **$0.00** |
| TRS | **3** | **$0.00** |
| Anonymous Callers | **1** | **$0.00** |
| CBH | **1** | **$0.00** |
| DentaQuest | **1** | **$0.00** |
| Member/ Parent / Guardian | **1** | **$0.00** |
| US Script | **1** | **$0.00** |
| **CBH** | | |
| CBH | **5** | **$0.00** |
| SIU | **2** | **$0.00** |
| SPHP | **1** | **$4,706.00** |
| Member | **1** | **$0.00** |
| **DentaQuest** | | |
| DentaQuest | **27** | **$21,353.16** |

| Referral Source | Cases Received | Dollars Involved* |
|---|---|---|
| **NIA** | | |
| NIA | **1** | **$0.00** |
| **OptiCare** | | |
| Medical Management Committee | **1** | **$5,063.02** |
| **TRS** | | |
| TRS | **42** | **$12,162.20** |
| **Grand Total** | **134** | **$2,221,467.77** |

**Amount represents estimated dollars as reported by each CMO.*

The following is a list of the top five member/provider types for potential fraud and abuse during the analysis period, ranked by the most to the least number of cases (Table 5).

**Table 5: PSHP's Top Five Types of Potential Fraud and Abuse**

| Member/Provider Type | Number of Cases |
|---|---|
| Speech Therapy (ST) | 18 |
| General | 16 |
| Pediatric Medicine | 12 |
| Speech Pathology (SP) | 10 |
| Member | 7 |

Of the top five potential fraud and abuse complaints, overutilization-excessive service, billing contract limit was most commonly referred with 30 cases. Table 6 lists the top five complaints reported by PSHP and its subcontractors during the analysis period, ranked by the most to the least number of cases.

**Table 6: PSHP's Top Five Potential Fraud and Abuse Complaints**

| Potential Fraud or Abuse | Number of Cases |
|---|---|
| Overutilization-excessive services, billing contract limit | 30 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 15 |
| Description, not provided | 14 |
| Upcoding the level of service provided | 14 |
| Provider over prescribing/prescription fraud | 11 |

## Disposition of Cases

As of the November 2012 report, PSHP and its subcontractors reported a total of 78 open cases accounting for $2,059,281.27. Of the 78 open cases, 25 cases exceed 365 days from the date the case or lead was entered on the report. The dollars involved in these cases were $2,047,347.39.

Of the 134 reported cases, PSHP closed 12 cases accounting for $47,910.01 during the analysis period. Collectively, PSHP's subcontractors closed 27 cases which accounted for $25,190.08. Myers and Stauffer was unable to clearly document the total number of recoupments or recoveries associated with these cases.

During the analysis period, there were 17 open cases or leads for PSHP, DentaQuest, NIA and TRS that did not appear on the November 2012 report. The dollars involved in these cases were $99,398.34. For these cases, Myers and Stauffer expected the CMO to indicate a disposition of "Closed", "Cleared", "Inactive", or "Referred" on a case or lead prior to removing it from a monthly report.

### Additional PSHP Findings

- PSHP referred 45% of the reported cases to the Department of Community Health Office of Inspector General, the Medicaid Fraud Control Unit, or another agency.
- The average time to close a case is 166 days for PSHP and/or its subcontractors.
- PSHP frequently failed to report the dollars involved on the Fraud and Abuse monthly reports.
- The existing Fraud and Abuse report template lacked an efficient means of reporting pertinent information such accurate account for cases opened and closed, tracking of pending and referred cases, and total dollars recovered.

## WELLCARE

WellCare and its subcontractors (Avesis [Vision], DentaQuest [Dental], and Magellan [Behavioral Health]) reported 781 cases of potential fraud and abuse. The dollars involved in these cases were $3,032,364.63.

During the analysis period, for WellCare, the primary referral source of potential fraud and abuse complaints was external hotline calls/web portal submissions which totaled 315 cases. Internal hotline calls/grievance referrals were the next highest referral source of complaints with 115 cases. Avesis, Dentaquest, and Magellan, all subcontractors, accounted for 69 cases received. See Table 7 for a detailed listing of cases received by referral source.

**Table 7: CMO Case Referral Summary for 1/1/12 through 11/30/12 Referred From:**

| Referral Source | Cases Received | Dollars Involved* |
|---|---|---|
| **WellCare** | | |
| External Hotline Calls/Web portal submissions | **315** | **$23,104.00** |
| Internal Hotline Calls/Grievance Referral | **115** | **$308,097.78** |
| GA-SVC Verification Letter | **95** | **$0.00** |
| MFCU | **79** | **$0.00** |
| Payment Optimizer | **30** | **$116,588.78** |
| Data Mining | **26** | **$535,064.14** |
| Member/ Parent / Guardian | **14** | **$0.00** |
| Inspector- Behavioral Analysis Profile | **13** | **$0.00** |

| Referral Source | Cases Received | Dollars Involved* |
|---|---|---|
| Provider / Vendor | 9 | $0.00 |
| MEDIC | 7 | $0.00 |
| DCH | 6 | $24,236.00 |
| E&M Leveling Initiative | 3 | $0.00 |
| **Avesis** | | |
| Claims data reports | 1 | $27,790.72 |
| **DentaQuest** | | |
| UR Dept, Data Analysis | 13 | $23,050.13 |
| Dental Mgmt | 1 | $0.00 |
| News source | 1 | $707.00 |
| **Magellan** | | |
| MFCU | 12 | $901,517.00 |
| Concerned Citizen | 10 | $102,509.52 |
| Careworker | 5 | $5,585.00 |
| Member/ Parent / Guardian | 5 | $3,486.46 |
| Magellan Care Manager | 4 | $609.00 |
| Magellan Employee | 3 | $53,789.00 |
| Anonymous Caller | 2 | $682.00 |
| Former Employee Whistleblower | 2 | $204,035.00 |
| Fraud Hotline | 2 | $641.36 |
| NHCAA SIRIS | 2 | $75,000.00 |
| WellCare Verification Letter | 2 | $801.00 |
| Compliance Hotline | 1 | $24,875.74 |
| Other | 1 | $195.00 |
| Provider/Office Staff | 1 | $0.00 |
| Whistleblower | 1 | $600,000.00 |
| **Grand Total** | **781** | **$3,032,364.63** |

**Amount represents estimated dollars as reported by each CMO.*

The following is a list of the top five member/provider types for potential fraud and abuse during the analysis period, ranked by the most to the least number of cases (Table 8).

**Table 8: WellCare's Top Five Types of Potential Fraud and Abuse**

| Member/Provider Type | Number of Cases |
|---|---|
| Pediatrics (PED) | 53 |
| Family Practice (FP) | 28 |
| Hospital (HOSP) | 21 |
| Internal Medicine (IM) | 21 |
| Practitioner | 18 |

Of the top five potential fraud and abuse complaints, provider allegedly improperly disposed of member medical records was most commonly referred with 196 cases. Table 9 lists the top five complaints reported by WellCare and its subcontractors during the analysis period, ranked by the most to the least number of cases.

**Table 9: WellCare's Top Five Potential Fraud and Abuse Complaints**

| Potential Fraud or Abuse | Number of Cases |
|---|---|
| Provider allegedly improperly disposed of members medical records. | 196 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 140 |
| Self-Referral | 91 |
| Upcoding the level of service provided | 52 |
| Other | 38 |

### Disposition of Cases

As of November 2012, WellCare and its subcontractors reported 365 open cases accounting for $905,041.90. Of the 365 cases, 111 cases exceed 365 days from the date the case or lead was entered on the report. The dollars involved in these cases were $778,051.66. Of the 781 reported cases, WellCare closed 306 cases with $193,748.00 involved. Collectively, WellCare's subcontractors closed 53 cases with $1,923,221.73 involved. Myers and Stauffer was unable to clearly document the total number of recoupments or recoveries associated with these cases.

During the analysis period, there were 57 open cases or leads for WellCare, DentaQuest and Magellan that did not appear on the November 2012 report. The dollars involved for these cases were $10,353.00. For these cases, Myers and Stauffer expected the CMO to indicate a disposition of "Closed", "Cleared", "Inactive", or "Referred" on a case or lead prior to removing it from a monthly report.

## Additional WellCare Findings

- WellCare referred 25% of reported cases of the reported cases to the Department of Community Health Office of Inspector General, the Medicaid Fraud Control Unit, or another agency.
- The average time to close a case is 145 days by WellCare and/or its subcontractors.
- WellCare reported the most fraud and abuse cases or leads when compared to AGP and PSHP.
- Non-reporting of dollars involved and missing entries in the nature of complaint columns were noted on the Fraud and Abuse monthly reports.
- The existing Fraud and Abuse report template lacked an efficient means of reporting pertinent information such as accurate account for cases opened and closed, tracking of pending and referred cases, and total dollars recovered.

# Recommendations

In order to enhance the value, accuracy and effectiveness of the Fraud and Abuse Reports, Myers and Stauffer makes the following recommendations:

- Require each CMO to implement documented quality assurance measures to review the reported data for accuracy and completeness before it is submitted to DCH.
- Require mandatory referring of cases to the Department of Community Health Office of Inspector General, the Medicaid Fraud Control Unit, or another agency after a specified time period.
- Implement best practice requirements to coincide with the use of the existing Fraud and Abuse report template such as:
  - Identify required fields to enter data such as nature of complaint
  - Restrict the entry of data in specified fields
  - Standardize disposition status
  - Report total dollars recouped and/or recovered for the reporting month
- Implement a revised template for Fraud and Abuse quarterly reporting. Myers and Stauffer proposes the implementation of the Fraud and Abuse Reporting Performance Metrics, provided in Exhibit 4, which includes instructions.
- Add the Fraud and Abuse Reporting Performance Metrics as a quarterly reporting requirement in their model contract with the CMOs.
- Include a provision that requires that the CMOs not change or alter, in any form or function, the Fraud and Abuse Reporting Performance Metrics template without DCH's written consent.

# *Exhibits*

**Exhibit 1**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 1: Status of all Cases Reported During Analysis Period 1/1/2012 - 11/30/2012**

| AGP | Number of Cases |
|---|---|
| Case Cleared | 10 |
| Case Conditionally Cleared | 32 |
| Case Open | 37 |
| Lead Cleared | 2 |
| Lead Closed | 12 |
| Lead Open | 34 |
| **Total** | **127** |

| Caremark | Number of Cases |
|---|---|
| Case Cleared | 1 |
| Case Open | 3 |
| **Total** | **4** |

| DentaQuest/Doral | Number of Cases |
|---|---|
| Case Conditionally Cleared | 1 |
| **Total** | **1** |

| Scion | Number of Cases |
|---|---|
| Case Cleared | 3 |
| Case Open | 8 |
| **Total** | **11** |

| | |
|---|---|
| **Grand Total** | **143** |
| **Approximate Dollars Involved** | **$30,896,826.49** |

**Exhibit 1**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 2: Categorical Information on Cases During Analysis Period 1/1/2012 - 11/30/2012**

**AGP**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Member | 18 | $139,889.74 |
| Addiction Medicine | 1 | $31,310.00 |
| Allergy | 1 | $673,994.55 |
| Ambulance | 1 | $939,998.28 |
| Behavioral Health | 4 | $635,353.76 |
| Birthing Center | 1 | $0.00 |
| Diagnostic Radiology | 1 | $0.00 |
| Dietitian/Nutritional Services | 1 | $74,853.00 |
| DME & Supplies | 3 | $982,934.37 |
| Emergency Medicine | 1 | $898,393.12 |
| Family Medicine Specialist | 1 | $0.00 |
| Family Planning Services | 1 | $93,933.00 |
| Family Practice | 6 | $2,327,610.84 |
| General Practice | 5 | $585,115.23 |
| Gynecology - No Obstetrics | 2 | $256,934.90 |
| Hematology / Oncology | 1 | $291,513.86 |
| Hospital | 1 | $81.98 |
| Internal Medicine | 1 | $248,870.49 |
| Lic Clinical Social Worker | 2 | $499,354.72 |
| Lic Professional Counselor | 14 | $1,016,629.46 |
| Maternal / Fetal Medicine | 1 | $832,663.89 |
| Neurology | 1 | $127,182.00 |
| Obstetrics / Gynecology | 11 | $9,372,447.10 |
| Occupational Therapy | 2 | $37,363.84 |
| OP Mental Hlth/Substance Abuse | 2 | $275,557.30 |
| Ophthalmology | 2 | $143,603.41 |
| Orthopaedic Surgery | 1 | $57,069.45 |
| Pain Management | 1 | $6,932.18 |
| Pediatric Cardiology | 1 | $63,395.00 |
| Pediatric Neurology | 1 | $22,172.00 |
| Pediatrics | 12 | $6,083,880.38 |
| Physical Medicine and Rehab | 1 | $822,052.06 |
| Podiatry | 1 | $897.87 |
| Primary Care | 1 | $0.00 |
| Psychiatry | 3 | $572,426.49 |
| Psychiatry, Child | 2 | $236,400.00 |
| Psychology | 5 | $533,136.91 |
| Radiation Oncology | 1 | $922,703.14 |
| Speech Therapy / Pathology | 5 | $330,976.09 |
| Speech Therapy Services | 2 | $132,673.29 |
| Surgery, Orthopedic | 1 | $19,683.00 |
| Unknown | 2 | $7,775.56 |
| N/A | 2 | $0.00 |

**Caremark**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Member | 1 | $5,127.17 |
| Family Practice | 1 | $155,228.72 |
| Pharmacy | 2 | $179,516.00 |

**DentaQuest / Doral**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Family Dentistry | 1 | $28,844.34 |

**Scion**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Dental | 6 | $0.00 |
| Family Dentistry | 4 | $230,348.00 |
| Vendor - Dental Services | 1 | $0.00 |

| | | |
|---|---|---|
| **Grand Total** | **143** | **$30,896,826.49** |

**Exhibit 1**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 3: Potential Fraud and Abuse Issues During Analysis Period 1/1/2012 - 11/30/2012**

**AGP**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Prescription Drug Diversion, Misuse and Addiction | 1 | $0.00 |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 8 | $71,049.78 |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed-Prescription Fraud/Tampering | 2 | $8,757.14 |
| Loaning his/her Medicaid Identification card to another person | 1 | $150.93 |
| A non-recipient uses a recipient's card with or without the recipient's knowledge-Application misrepresentation by member | 3 | $9,590.76 |
| Using a stolen Medicaid Identification card | 1 | $0.00 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 5 | $352,510.29 |
| Billing for nonexistent patients or patients of other providers | 2 | $132,673.29 |
| Altering Claim/Bill/Falsifying Records/Documents | 3 | $214,043.56 |
| Balance Billing Patient | 2 | $205,229.47 |
| Forgery | 3 | $92,419.55 |
| Provider over prescribing/prescription fraud | 9 | $591,288.20 |
| Improper/Inappropriate billing practices (i.e. misuse of modifier) | 2 | $0.00 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 22 | $2,323,886.04 |
| Provider allegedly improperly disposed of members medical records. | 1 | $52,827.80 |
| Subcontractor/Vendor Complaint | 1 | $0.00 |
| Providing services, supplies, or equipment that are not medically necessary | 3 | $511,401.49 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 7 | $498,865.59 |
| Upcoding the level of service provided | 13 | $5,679,541.46 |
| Misrepresentation of the provision of services/diagnosis; documentation insufficient | 4 | $261,885.27 |
| Unbundling a global or all-inclusive fee | 1 | $1,161,294.53 |
| Overutilization-excessive services, billing contract limit | 30 | $17,972,639.49 |
| Other | 3 | $157,707.62 |

**Caremark**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Forgery | 4 | $339,871.89 |

**DentaQuest / Doral**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Overutilization-excessive services, billing contract limit | 1 | $28,844.34 |

**Scion**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Overutilization-excessive services, billing contract limit | 11 | $230,348.00 |

| | | |
|---|---|---|
| **Grand Total** | **143** | **$30,896,826.49** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 4: Open Cases/Leads as of 11/30/2012**

| AGP | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 5/14/2012 | 1 | $22,732.41 | 200 |
| | 6/27/2012 | 1 | $4,137.38 | 156 |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed- Prescription Fraud/Tampering | 5/18/2012 | 1 | $0.00 | 196 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 9/26/2011 | 1 | $0.00 | 431 |
| | 8/9/2012 | 1 | $0.00 | 113 |
| | 4/29/2011 | 1 | $23,043.00 | 581 |
| Billing for nonexistent patients or patients of other providers | 4/19/2012 | 1 | $62,892.16 | 225 |
| Altering Claim/Bill/Falsifying Records/Documents | 10/11/2012 | 1 | $7,775.56 | 50 |
| Balance Billing Patient | 9/4/2012 | 1 | $0.00 | 87 |
| Provider over prescribing/prescription fraud | 11/21/2011 | 1 | $4,045.94 | 375 |
| | 3/1/2010 | 1 | $8,129.25 | 1005 |
| | 10/2/2012 | 1 | $0.00 | 59 |
| | 3/15/2012 | 1 | $112,574.67 | 260 |
| Improper/Inappropriate billing practices (i.e. misuse of modifier) | 11/6/2012 | 1 | $0.00 | 24 |
| | 11/6/2012 | 1 | $0.00 | 24 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 11/27/2012 | 1 | $81.98 | 3 |
| | 10/26/2012 | 1 | $0.00 | 35 |
| | 4/23/2012 | 1 | $158,203.50 | 221 |
| | 4/14/2011 | 1 | $53,935.00 | 596 |
| | 6/10/2011 | 1 | $91,483.00 | 539 |
| | 3/28/2012 | 1 | $922,703.14 | 247 |
| | 10/24/2012 | 1 | $3,805.20 | 37 |
| Provider allegedly improperly disposed of members medical records. | 10/12/2012 | 1 | $52,827.80 | 49 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 9/20/2012 | 1 | $0.00 | 71 |
| | 4/14/2010 | 1 | $93,933.00 | 961 |
| | 3/29/2010 | 1 | $4,898.00 | 977 |
| | 3/26/2012 | 1 | $29,234.59 | 249 |
| Upcoding the level of service provided | 9/23/2009 | 1 | $898,393.12 | 1164 |
| | 11/29/2012 | 1 | $832,663.89 | 1 |
| | 9/17/2009 | 2 | $1,987,215.00 | 1170 |
| | 11/30/2009 | 1 | $620,801.79 | 1096 |
| | 8/5/2011 | 1 | $17,484.00 | 483 |
| Overutilization-excessive services, billing contract limit | 6/19/2012 | 1 | $673,994.55 | 164 |
| | 7/30/2012 | 1 | $939,998.28 | 123 |
| | 9/24/2010 | 1 | $520,582.44 | 798 |
| | 8/5/2011 | 1 | $1,370,258.80 | 483 |
| | 6/19/2012 | 1 | $634,459.57 | 164 |
| | 6/20/2012 | 1 | $491,842.19 | 163 |
| | 4/3/2012 | 4 | $7,650,522.61 | 241 |
| | 8/14/2012 | 1 | $0.00 | 108 |
| | 5/16/2012 | 1 | $1,165,995.87 | 198 |
| | 5/22/2012 | 1 | $1,760,341.15 | 192 |
| | 11/9/2012 | 1 | $128,900.91 | 21 |
| | 6/20/2012 | 1 | $822,052.06 | 163 |
| | 10/14/2009 | 1 | $237,089.00 | 1143 |

**Exhibit 1**

| Caremark | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Forgery | 3/30/2010 | 1 | $5,127.17 | 976 |
| | 6/23/2010 | 1 | $155,228.72 | 891 |

| Scion | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Overutilization-excessive services, billing contract limit | 10/25/2012 | 6 | $0.00 | 36 |
| | 11/2/2011 | 1 | $44,200.00 | 394 |
| | 10/25/2012 | 1 | $0.00 | 36 |

| | | | |
|---|---|---|---|
| **Grand Total** | **59** | **$22,613,586.70** | |

**Exhibit 1**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 5: Closed Cases/Leads as of 11/30/2012**

| CMO/Subcontractor | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| AGP | 56 | $5,780,645.19 |
| Caremark | 1 | $0.00 |
| DentaQuest / Doral | 1 | $28,844.34 |
| Scion | 3 | $186,148.00 |
| **Grand Total** | **61** | **$5,995,637.53** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

### Table 6: Open Cases/Leads Missing from Report as of November 2012

| AGP | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 2/15/2012 | 1 | $0.00 | None at this time |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed-Prescription Fraud/Tampering | 9/28/2012 | 1 | $8,757.14 | Undetermined |
| A non-recipient uses a recipient's card with or without the recipient's knowledge-Application misrepresentation by member | 1/4/2012 | 1 | $2,543.97 | Evidence Does Not Support Lead |
| | 5/4/2012 | 1 | $0.00 | None at this time |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 6/5/2012 | 1 | $248,870.49 | Transferred to Case |
| Billing for nonexistent patients or patients of other providers | 4/19/2012 | 1 | $69,781.13 | None at this time |
| | 9/17/2012 | 1 | $57,069.45 | Undetermined |
| Provider over prescribing/prescription fraud | 9/20/2012 | 1 | $291,513.86 | Undetermined |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 4/16/2012 | 1 | $8,130.00 | Undetermined |
| | 8/17/2012 | 1 | $77,514.58 | Evidence Does Not Support Lead |
| | 8/17/2012 | 1 | $77,514.58 | None at this time |
| | 8/20/2012 | 1 | $44,397.87 | Evidence Does Not Support Lead |
| | 7/6/2012 | 1 | $129,827.58 | Undetermined |
| Providing services, supplies, or equipment that are not medically necessary | 7/26/2012 | 1 | $282,597.87 | Undetermined |
| Upcoding the level of service provided | 9/11/2012 | 1 | $203,759.66 | Undetermined |
| Overutilization-excessive services, billing contract limit | 8/20/2012 | 1 | $0.00 | Undetermined |
| | 8/16/2012 | 1 | $425,928.46 | Undetermined |
| | 8/20/2012 | 2 | $0.00 | Undetermined |
| | 8/30/2011 | 1 | $22,172.00 | Undetermined |
| Subcontractor/Vendor Complaint | 6/7/2012 | 1 | $0.00 | None at this time |
| Other | 9/7/2012 | 1 | $157,707.62 | Undetermined |
| **Caremark** | | | | |
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Forgery | 3/25/2010 | 1 | $179,516.00 | None at this time |
| **Grand Total** | | **23** | **$2,287,602.26** | |

**Exhibit 1**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - AGP**

**Table 7: Case Referrals**

| Referral Source | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| **AGP** | | |
| DCH | 6 | $161,694.03 |
| DCH/FBI | 1 | $266,233.00 |
| DCH/MFCU | 2 | $193,242.18 |
| GA-DOI | 2 | $286,864.80 |
| MFCU | 6 | $2,370,363.70 |
| Unknown | 2 | $236,188.04 |
| None at this time | 108 | $26,783,176.51 |
| **Caremark** | | |
| None at this time | 4 | $339,871.89 |
| **DentaQuest / Doral** | | |
| None at this time | 1 | $28,844.34 |
| **Scion** | | |
| None at this time | 11 | $230,348.00 |
| **Grand Total** | **143** | **$30,896,826.49** |

**Exhibit 2**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 1: Status of all Cases Reported During Analysis Period 1/1/2012 - 11/30/2012**

| PSHP | Number of Cases |
|---|---|
| Open | 46 |
| Active | 1 |
| Closed | 8 |
| Closed-Recoupment | 4 |
| Open-Awaiting records | 1 |
| **Total** | **60** |

| CBH | Number of Cases |
|---|---|
| Closed | 2 |
| Open | 7 |
| **Total** | **9** |

| DentaQuest | Number of Cases |
|---|---|
| Closed | 2 |
| Closed-Recoupment | 5 |
| Open | 1 |
| Open- Investigation on hold | 2 |
| Open-Active investigation in process | 4 |
| Open-Awaiting records | 6 |
| Peer Review Process | 1 |
| Reopened on hold | 1 |
| **Total** | **22** |

| NIA | Number of Cases |
|---|---|
| Authorization was approved | 1 |
| **Total** | **1** |

| Optica | Number of Cases |
|---|---|
| Closed-Recoupment | 1 |
| **Total** | **1** |

| TRS | Number of Cases |
|---|---|
| Active | 10 |
| Active (on hold) | 1 |
| Closed | 15 |
| On-going investigation | 13 |
| Recoupment on HOLD as per State and PSHP request | 1 |
| Unknown | 1 |
| **Total** | **41** |

| | |
|---|---|
| **Grand Total** | **134** |
| **Approximate Dollars Involved** | **$2,221,467.77** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 2: Categorical Information on Cases During Analysis Period 1/1/2012 - 11/30/2012**

**PSHP**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Allergy/ Immunology | 2 | $62.71 |
| Asthma and Allergy Group | 1 | $0.00 |
| Dermatologist | 1 | $0.00 |
| Family Practice | 1 | $0.00 |
| Gastroenterology | 1 | $14,234.00 |
| General | 3 | $2,721.22 |
| General Practice | 1 | $0.00 |
| General Surgeon | 1 | $0.00 |
| Hospital | 6 | $1,274,493.70 |
| Independent Clinical Laboratory | 1 | $0.00 |
| Internal Medicine | 1 | $60,264.12 |
| Internal Medicine Physician | 1 | $0.00 |
| Internal Medicine, Family Practice | 1 | $0.00 |
| Medical Clinic | 1 | $0.00 |
| Multi Specialty Clinic | 3 | $5,508.48 |
| Multiple Specialties | 2 | $39,282.00 |
| N/A - Member | 7 | $1,966.08 |
| Nurse Practitioner | 1 | $0.00 |
| Obstetrics / Gynecology | 6 | $46,851.62 |
| Occupational Therapist | 1 | $0.00 |
| Orthopedic Surgery | 1 | $75,381.00 |
| Otolaryngology | 1 | $8,658.00 |
| Pediatric Dentistry | 3 | $1,370.53 |
| Pediatric Medicine | 12 | $651,481.68 |
| ST | 1 | $0.00 |

**CBH**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Medical Clinic | 4 | $0.00 |
| Psychiatrist | 1 | $0.00 |
| Psychologist | 3 | $4,706.00 |
| Social Worker | 1 | $0.00 |

**DentaQuest**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Anesthesiologist | 1 | $0.00 |
| General | 13 | $2,625.12 |
| General Dentist | 1 | $0.00 |
| Oral Surgeon | 1 | $0.00 |
| Oral Surgeon/MD | 4 | $8,568.69 |
| Pediatric Dentistry | 2 | $6,067.60 |

**NIA**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Radiology | 1 | $0.00 |

**Opticar**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Optometrist | 1 | $5,063.02 |

**Exhibit 2**

| TRS | | |
|---|---|---|
| **Classification of Subject** | **Number of Cases** | **Approximate Dollars Involved** |
| ST | 1 | $750.36 |
| Advance Rehab for Kids of Gordon County | 1 | $0.00 |
| Communication Partners | 1 | $0.00 |
| District 4 Health Services - Babies Can't Wait | 1 | $0.00 |
| Hearts & Hand Therapy Services | 1 | $0.00 |
| Moon River Pediatric Therapy | 1 | $0.00 |
| OT | 4 | $0.00 |
| Phoebe Putney Memorial Hospital | 1 | $0.00 |
| PT | 1 | $0.00 |
| Sai Rehab | 1 | $0.00 |
| SP | 10 | $314.00 |
| ST | 16 | $9,354.60 |
| The Speech and Swallowing Clinic | 1 | $0.00 |
| Therapy Works Pediatric Center | 1 | $1,743.24 |
| **Grand Total** | **134** | **$2,221,467.77** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 3: Potential Fraud and Abuse Issues During Analysis Period 1/1/2012 - 11/30/2012**

**PSHP**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| A member misrepresents their identity and eligibility citizenship to receive a benefits | 1 | $0.00 |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 1 | $0.00 |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed-Prescription Fraud/Tampering | 1 | $0.00 |
| Using a stolen Medicaid Identification card | 2 | $1,966.08 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 3 | $6,274.45 |
| Balance Billing Patient | 1 | $0.00 |
| Forgery | 3 | $825.89 |
| Provider over prescribing/prescription fraud | 8 | $18,801.52 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 8 | $52,310.74 |
| Billing contrary to Medicaid Policy | 1 | $0.00 |
| Fraud | 1 | $0.00 |
| Providing services, supplies, or equipment that are not medically necessary | 2 | $1,275,564.00 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 4 | $21,821.70 |
| Upcoding the level of service provided | 9 | $83,686.97 |
| Unbundling a global or all-inclusive fee | 8 | $688,617.30 |
| Overutilization-excessive services, billing contract limit | 6 | $32,406.49 |
| Unknown | 1 | $0.00 |

**CBH**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Billing for services, supplies, or equipment not rendered; unnecessary services | 4 | $4,706.00 |
| Provider allegedly improperly disposed of members medical records. | 1 | $0.00 |
| Providing services, supplies, or equipment that are not medically necessary | 1 | $0.00 |
| Overutilization-excessive services, billing contract limit | 1 | $0.00 |
| Unknown | 2 | $0.00 |

**DentaQuest**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Upcoding the level of service provided | 3 | $0.00 |
| Overutilization-excessive services, billing contract limit | 17 | $17,261.41 |
| Unknown | 2 | $0.00 |

**NIA**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Fraud | 1 | $0.00 |

**Exhibit 2**

| Optica | | |
|---|---|---|
| **Potential Abuse** | **Number of Cases** | **Approximate Dollars Involved** |
| Providing services, supplies, or equipment that are not medically necessary | 1 | $5,063.02 |

| TRS | | |
|---|---|---|
| **Potential Abuse** | **Number of Cases** | **Approximate Dollars Involved** |
| A member misrepresents their identity and eligibility citizenship to receive a benefits | 1 | $0.00 |
| Altering Claim/Bill/Falsifying Records/Documents | 1 | $0.00 |
| Provider over prescribing/prescription fraud | 3 | $0.00 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 3 | $3,376.62 |
| Billing contrary to Medicaid Policy | 5 | $0.00 |
| Providing services, supplies, or equipment that are not medically necessary | 4 | $314.00 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 2 | $5,442.06 |
| Upcoding the level of service provided | 2 | $0.00 |
| Misrepresentation of the provision of services/diagnosis; documentation insufficient | 5 | $1,286.28 |
| Overutilization-excessive services, billing contract limit | 6 | $0.00 |
| Unknown | 9 | $1,743.24 |

| **Grand Total** | **134** | **$2,221,467.77** |
|---|---|---|

**Exhibit 2**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 4: Open Cases/Leads as of 11/30/2012**

| PSHP | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| A member misrepresents their identity and eligibility citizenship to receive a benefits | 6/19/2012 | 1 | $0.00 | 164 |
| Obtaining Medicaid benefits that they were not entitled to through other fraudulent means | 5/17/2012 | 1 | $0.00 | 197 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 10/5/2011 | 1 | $0.00 | 422 |
| Balance Billing Patient | 4/8/2011 | 1 | $0.00 | 602 |
| Forgery | 12/22/2010 | 1 | $0.00 | 709 |
| | 8/31/2012 | 1 | $0.00 | 91 |
| Provider over prescribing/prescription fraud | 6/29/2011 | 1 | $18,318.30 | 520 |
| | 7/14/2011 | 1 | $0.00 | 505 |
| | 10/19/2011 | 1 | $0.00 | 408 |
| | 12/22/2011 | 1 | $0.00 | 344 |
| | 3/9/2012 | 1 | $0.00 | 266 |
| | 3/30/2012 | 1 | $0.00 | 245 |
| | 6/28/2012 | 1 | $0.00 | 155 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 8/31/2010 | 1 | $39,282.00 | 822 |
| | 6/10/2011 | 1 | $13,028.74 | 539 |
| | 9/15/2011 | 1 | $0.00 | 442 |
| | 11/17/2011 | 1 | $0.00 | 379 |
| | 5/17/2012 | 1 | $0.00 | 197 |
| | 8/10/2012 | 2 | $0.00 | 112 |
| Fraud | 9/6/2012 | 1 | $0.00 | 85 |
| Providing services, supplies, or equipment that are not medically necessary | 4/25/2011 | 1 | $1,266,906.00 | 585 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 8/31/2010 | 1 | $0.00 | 822 |
| | 2/10/2011 | 1 | $14,234.00 | 659 |
| | 8/10/2012 | 1 | $0.00 | 112 |
| Upcoding the level of service provided | 5/12/2010 | 1 | $75,381.00 | 933 |
| | 12/1/2010 | 1 | $0.00 | 730 |
| | 4/29/2011 | 1 | $0.00 | 581 |
| | 5/16/2011 | 1 | $62.71 | 564 |
| | 9/1/2011 | 1 | $0.00 | 456 |
| | 9/29/2011 | 1 | $8,243.26 | 428 |
| | 6/28/2012 | 1 | $0.00 | 155 |
| Unbundling a global or all-inclusive fee | 1/27/2010 | 1 | $454,904.64 | 1038 |
| | 10/20/2010 | 1 | $139,434.00 | 772 |
| | 2/25/2011 | 1 | $25,796.00 | 644 |
| | 5/16/2011 | 1 | $0.00 | 564 |
| Overutilization-excessive services, billing contract limit | 9/21/2012 | 1 | $0.00 | 70 |
| | 9/24/2012 | 1 | $0.00 | 67 |
| | 11/19/2012 | 1 | $0.00 | 11 |

## Exhibit 2

| TRS | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Altering Claim/Bill/Falsifying Records/Documents | 11/20/2011 | 1 | $0.00 | 376 |
| Provider over prescribing/prescription fraud | 5/24/2011 | 1 | $0.00 | 556 |
| | 11/20/2011 | 1 | $0.00 | 376 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 4/11/2012 | 1 | $0.00 | 233 |
| | 4/17/2012 | 1 | $3,376.62 | 227 |
| | 8/8/2012 | 1 | $0.00 | 114 |
| Billing contrary to Medicaid Policy | 11/20/2011 | 1 | $0.00 | 376 |
| | 11/29/2011 | 2 | $0.00 | 367 |
| | 9/4/2012 | 1 | $0.00 | 87 |
| Providing services, supplies, or equipment that are not medically necessary | 5/23/2011 | 1 | $314.00 | 557 |
| | 11/20/2011 | 1 | $0.00 | 376 |
| | 11/29/2011 | 1 | $0.00 | 367 |
| Provider not enrolled/ unlicensed/ misrepresentation of | 11/29/2011 | 1 | $0.00 | 367 |
| Upcoding the level of service provided | 12/1/2010 | 1 | $0.00 | 730 |
| | 4/17/2012 | 1 | $0.00 | 227 |
| Misrepresentation of the provision of services/diagnosis; | 12/1/2010 | 1 | $0.00 | 730 |
| Overutilization-excessive services, billing contract limit | 12/1/2010 | 1 | $0.00 | 730 |
| | 7/6/2012 | 1 | $0.00 | 147 |

| CBH | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 12/22/2011 | 2 | $0.00 | 344 |
| Provider allegedly improperly disposed of members medical records. | 4/5/2012 | 1 | $0.00 | 239 |
| Providing services, supplies, or equipment that are not medically necessary | 3/31/2010 | 1 | $0.00 | 975 |
| Overutilization-excessive services, billing contract limit | 3/30/2012 | 1 | $0.00 | 245 |
| Other | 11/6/2012 | 2 | $0.00 | 24 |

| DentaQuest | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of time on Report (calendar days)** |
| Upcoding the level of service provided | 1/21/2011 | 1 | $0.00 | 679 |
| Overutilization-excessive services, billing contract limit | 4/24/2012 | 2 | $0.00 | 220 |
| | 5/25/2012 | 1 | $0.00 | 189 |
| | 6/20/2012 | 1 | $0.00 | 163 |
| | 7/30/2012 | 1 | $0.00 | 123 |
| | 8/15/2012 | 1 | $0.00 | 107 |
| | 8/28/2012 | 4 | $0.00 | 94 |
| | 11/9/2012 | 2 | $0.00 | 21 |

| | | | |
|---|---|---|---|
| **Grand Total** | **78** | **$2,059,281.27** | |

**Exhibit 2**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 5: Closed Cases/Leads as of 11/30/2012**

| CMO/Subcontractor | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| PSHP | 7 | $43,818.26 |
| CBH | 2 | $4,706.00 |
| DentaQuest | 13 | $12,784.47 |
| Optical | 1 | $5,063.02 |
| TRS | 16 | $6,728.34 |
| **Grand Total** | **39** | **$73,100.09** |

**Exhibit 2**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 6: Open Cases/Leads Missing from Report as of November 2012**

| PSHP | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 3/30/2011 | 1 | $3,623.08 | Unbundling services from Health Checks, incorrect E/M levels with Health Checks, not using appropriate antepartum care codes |
| Provider over prescribing/prescription fraud | 5/16/2011 | 1 | $483.22 | Billing high level E/Ms with Health Checks |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 3/5/2010 | 1 | $7,587.70 | CFY performing services |
| Upcoding the level of service provided | 6/28/2012 | 1 | $0.00 | None at this time |
| | 6/29/2012 | 1 | $0.00 | None at this time |
| Unbundling a global or all-inclusive fee | 11/2/2009 | 1 | $60,264.12 | Missing documentation, services billed by a provider other than servicing provider, unbundling services from Health Checks |
| | 1/27/2011 | 1 | $6,369.28 | Unbundling total OB care, unbundling 76819 and 59025 |
| | 8/26/2011 | 1 | $447.08 | Unbundling OB care |

| DentaQuest | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Overutilization-excessive services, billing contract limit | 1/30/2012 | 1 | $8,568.69 | None at this time |

| NIA | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Fraud | 3/5/2012 | 1 | $0.00 | Clinical information verified, Authorization approved. |

| TRS | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Providing services, supplies, or equipment that are not medically necessary | 10/3/2012 | 6 | $0.00 | None at this time |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 11/27/2012 | 1 | $1,743.24 | TRS has completed the prepayment review |

| | | | |
|---|---|---|---|
| **Grand Total** | **17** | **$89,086.41** | |

**Exhibit 2**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - PSHP**

**Table 7: Case Referrals**

| Referral Source | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| **PSHP** | | |
| DCH | 1 | $1,266,906.00 |
| DFACS | 1 | $1,966.08 |
| None at this time | 52 | $909,311.31 |
| **CBH** | | |
| SHCFCU | 1 | $0.00 |
| None at this time | 8 | $4,706.00 |
| **DentaQuest** | | |
| Peach State Health Plan | 13 | $12,784.47 |
| None at this time | 14 | $8,568.69 |
| **NIA** | | |
| Peach State Health Plan | 1 | $0.00 |
| **Optica** | | |
| Quality, Compliance | 1 | $5,063.02 |
| **TRS** | | |
| Peach State Health Plan | 42 | $12,162.20 |
| **Grand Total** | **134** | **$2,221,467.77** |

**Exhibit 3**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 1: Status of all Cases Reported During Analysis Period 1/1/2012 - 11/30/2012**

| WellCare | Number of Cases |
|---|---|
| Approved to Close Case | 1 |
| Case Closed | 278 |
| Coder Review | 7 |
| External Referral | 1 |
| Investigator Review | 359 |
| Law Enforcement Review | 2 |
| Legal Review | 8 |
| New Case Pending Manager Review | 51 |
| Nurse Review | 3 |
| Pending Approval - Close Case | 2 |
| **Total** | **712** |

| Avesis | Number of Cases |
|---|---|
| Findings are unchanged. In Finance for recovery. Requesting permission to close | 1 |
| **Total** | **1** |

| DentaQuest | Number of Cases |
|---|---|
| Case Closed | 3 |
| Closed- Terminated from the network | 1 |
| Closed-recoupment | 1 |
| Recoupment behavior modification | 4 |
| Recoupment case closed. | 1 |
| Other | 1 |
| Unknown | 4 |
| **Total** | **15** |

| Magellan | Number of Cases |
|---|---|
| Closed | 31 |
| Inactive | 1 |
| New | 2 |
| Open | 5 |
| Open/Active | 14 |
| **Total** | **53** |

| | |
|---|---|
| **Grand Total** | **781** |
| **Approximate Dollars Involved** | **$3,032,364.63** |

**Exhibit 3**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 2: Categorical Information on Cases During Analysis Period 1/1/2012 - 11/30/2012**

| WellCare | | |
|---|---|---|
| **Classification of Subject** | **Number of Cases** | **Approximate Dollars Involved** |
| ALLIMM | 1 | $0.00 |
| AMBCE | 3 | $0.00 |
| CARD | 3 | $0.00 |
| CHCENT | 4 | $0.00 |
| D.M.E. | 12 | $0.00 |
| DENT | 17 | $0.00 |
| DERM | 3 | $0.00 |
| DIAGIM | 1 | $19,238.00 |
| ENDOC | 2 | $0.00 |
| ENT | 4 | $0.00 |
| ER | 2 | $0.00 |
| FP | 28 | $75,804.00 |
| FQHC | 6 | $0.00 |
| GP | 4 | $0.00 |
| GS | 1 | $0.00 |
| HEMONC | 1 | $0.00 |
| HHCARE | 3 | $0.00 |
| HOSFP | 1 | $0.00 |
| HOSIM | 1 | $0.00 |
| HOSP | 21 | $65,727.00 |
| HOSPD | 1 | $0.00 |
| HOSPIC | 1 | $0.00 |
| IM | 21 | $13,657.63 |
| LAB | 7 | $0.00 |
| MENTH | 2 | $0.00 |
| NEURM | 5 | $116,163.05 |
| NEURO | 1 | $0.00 |
| NUTRI | 1 | $158,106.00 |
| OB/GYN | 12 | $0.00 |
| OPHTH | 2 | $0.00 |
| OPTOM | 1 | $0.00 |
| ORTHO | 3 | $0.00 |
| PATH | 5 | $0.00 |
| PED | 53 | $381,538.88 |
| PEDBD | 1 | $0.00 |
| PEDCAR | 1 | $0.00 |
| PEDER | 1 | $0.00 |
| PEDNEU | 1 | $28,942.36 |
| PHAR | 6 | $0.00 |
| PHYSTH | 5 | $0.00 |
| PLAS | 1 | $0.00 |
| PMR | 1 | $0.00 |
| PNMAN | 2 | $0.00 |
| POD | 1 | $0.00 |
| PSY | 1 | $0.00 |
| PSYCH | 3 | $0.00 |
| RAD | 5 | $0.00 |
| RADONC | 1 | $0.00 |
| RHC | 1 | $48,262.00 |
| SPEECH | 16 | $742.00 |
| URGENT | 4 | $0.00 |
| (blank) | 428 | $98,909.78 |

## Exhibit 3

**Avesis**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Vision | 1 | $27,790.72 |

**DentaQuest**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Anesthesiologist | 1 | $0.00 |
| General | 6 | $7,815.78 |
| General Dentist | 3 | $1,054.65 |
| Oral Surgeon | 3 | $14,876.26 |
| Oral Surgeon/MD | 1 | $0.00 |
| Pediatric Dentistry | 1 | $10.44 |

**Magellan**

| Classification of Subject | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Agency | 1 | $24,875.74 |
| Community MH | 1 | $500.00 |
| Facility | 1 | $0.00 |
| Group | 15 | $557,858.93 |
| Group Provider | 1 | $711.00 |
| Individual Provider | 11 | $88,630.41 |
| Member | 1 | $0.00 |
| Organization | 3 | $842,330.00 |
| Practitioner | 18 | $458,795.00 |
| Stolen I.D. | 1 | $25.00 |

| | | |
|---|---|---|
| **Grand Total** | **781** | **$3,032,364.63** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 3: Potential Fraud and Abuse Issues During Analysis Period 1/1/2012 - 11/30/2012**

**WellCare**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| A member misrepresents their identity and eligibility citizenship to receive a benefits | 2 | $16,404.00 |
| Prescription Drug Diversion, Misuse and Addiction | 1 | $0.00 |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed-Prescription Fraud/Tampering | 2 | $0.00 |
| Person consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotics, painkillers or other drugs-Doctor Shopping | 34 | $0.00 |
| Fraud | 17 | $0.00 |
| Using a stolen Medicaid Identification card | 21 | $0.00 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 11 | $0.00 |
| Underutilization of services, quality of care | 3 | $0.00 |
| Kickbacks/Rebates | 2 | $0.00 |
| Altering Claim/Bill/Falsifying Records/Documents | 2 | $0.00 |
| Balance Billing Patient | 9 | $0.00 |
| Forgery | 5 | $0.00 |
| Provider over prescribing/prescription fraud | 3 | $0.00 |
| Improper/Inappropriate billing practices (i.e. misuse of modifier) | 1 | $0.00 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 123 | $96,026.00 |
| Pharmacy provides less than the prescribed quantity and intentionally does not inform the patient but bills for the full amount (i.e., billing for 60 tablets, but only dispensing 30) | 4 | $0.00 |
| Pharmacy waives copays to entice members to use that store | 1 | $158,106.00 |
| Self-Referral | 87 | $0.00 |
| Data Request Only | 1 | $0.00 |
| Immediate close | 8 | $0.00 |
| Provider allegedly improperly disposed of members medical records. | 196 | $4,298.00 |
| Subcontractor/Vendor Complaint | 25 | $0.00 |
| Providing services, supplies, or equipment that are not medically necessary | 11 | $183,174.36 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services | 20 | $57,109.78 |
| Upcoding the level of service provided | 46 | $468,478.56 |
| Unbundling a global or all-inclusive fee | 2 | $0.00 |
| Overutilization-excessive services, billing contract limit | 9 | $23,494.00 |
| Other | 38 | $0.00 |
| Blank | 28 | $0.00 |

**Avesis**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Overutilization-excessive services, billing contract limit | 1 | $27,790.72 |

**DentaQuest**

| Potential Abuse | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| Provider over prescribing/prescription fraud | 2 | $0.00 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 2 | $4,413.28 |
| Fraud | 1 | $0.00 |

**Exhibit 3**

| | | |
|---|---|---|
| Provider allegedly improperly disposed of members medical records. | 1 | $707.00 |
| Upcoding the level of service provided | 3 | $568.20 |
| Overutilization-excessive services, billing contract limit | 6 | $18,068.65 |

**Exhibit 3**

| Magellan | | |
|---|---|---|
| **Potential Abuse** | **Number of Cases** | **Approximate Dollars Involved** |
| Using a stolen Medicaid Identification card | 1 | $25.00 |
| Billing for nonexistent patients or patients of other providers | 3 | $14,316.00 |
| Altering Claim/Bill/Falsifying Records/Documents | 2 | $228,875.74 |
| Balance Billing Patient | 3 | $77,380.41 |
| Provider over prescribing/prescription fraud | 3 | $1,752.00 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 15 | $663,985.66 |
| Self-Referral | 4 | $116,713.46 |
| Billing contrary to Medicaid Policy | 1 | $2,756.00 |
| Billing History | 10 | $784,866.00 |
| Upcoding the level of service provided | 3 | $5,472.00 |
| Unbundling a global or all-inclusive fee | 1 | $75,000.00 |
| Overutilization-excessive services, billing contract limit | 5 | $2,583.81 |
| Member Fraud | 1 | $0.00 |
| Provider Fraud | 1 | $0.00 |
| **Grand Total** | **781** | **$3,032,364.63** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 4: Open Cases/Leads as of 11/30/2012**

| WellCare | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of Time on Report (Calendar days)** |
| A member misrepresents their identity and eligibility citizenship to receive a benefits | 4/5/2010 | 1 | $16,404.00 | 970 |
| Creating a false prescription, supply order, or alters a valid prescription to obtain drugs or benefits not prescribed- Prescription Fraud/Tampering | 10/10/2012 | 1 | $0.00 | 51 |
| | 11/14/2012 | 1 | $0.00 | 16 |
| Person consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotics, painkillers or other drugs- Doctor Shopping | 11/3/2010 | 1 | $0.00 | 758 |
| | 11/19/2010 | 1 | $0.00 | 742 |
| | 2/10/2011 | 1 | $0.00 | 659 |
| | 3/23/2011 | 1 | $0.00 | 618 |
| | 4/8/2011 | 1 | $0.00 | 602 |
| | 4/11/2011 | 1 | $0.00 | 599 |
| | 9/2/2011 | 1 | $0.00 | 455 |
| | 10/31/2011 | 1 | $0.00 | 396 |
| | 4/2/2012 | 1 | $0.00 | 242 |
| | 4/4/2012 | 1 | $0.00 | 240 |
| | 4/16/2012 | 1 | $0.00 | 228 |
| | 6/14/2012 | 1 | $0.00 | 169 |
| | 7/11/2012 | 1 | $0.00 | 142 |
| | 7/17/2012 | 1 | $0.00 | 136 |
| | 7/20/2012 | 1 | $0.00 | 133 |
| | 7/21/2012 | 1 | $0.00 | 132 |
| | 7/24/2012 | 1 | $0.00 | 129 |
| | 8/1/2012 | 1 | $0.00 | 121 |
| | 8/14/2012 | 1 | $0.00 | 108 |
| | 8/21/2012 | 1 | $0.00 | 101 |
| | 8/25/2012 | 1 | $0.00 | 97 |
| | 9/13/2012 | 1 | $0.00 | 78 |
| | 10/1/2012 | 3 | $0.00 | 60 |
| | 10/3/2012 | 1 | $0.00 | 58 |
| Fraud | 10/30/2009 | 1 | $0.00 | 1127 |
| | 8/8/2011 | 1 | $0.00 | 480 |
| | 8/17/2011 | 1 | $0.00 | 471 |
| | 10/2/2012 | 1 | $0.00 | 59 |
| | 10/9/2012 | 1 | $0.00 | 52 |
| | 11/9/2012 | 1 | $0.00 | 21 |
| Using a stolen Medicaid Identification card | 10/2/2009 | 1 | $0.00 | 1155 |
| | 8/2/2011 | 1 | $0.00 | 486 |
| | 8/12/2011 | 1 | $0.00 | 476 |
| | 10/19/2011 | 1 | $0.00 | 408 |
| | 2/21/2012 | 1 | $0.00 | 283 |
| | 4/11/2012 | 1 | $0.00 | 233 |
| | 6/11/2012 | 2 | $0.00 | 172 |
| | 10/11/2012 | 1 | $0.00 | 50 |
| | 11/6/2012 | 1 | $0.00 | 24 |
| | 11/20/2012 | 1 | $0.00 | 10 |
| Billing for services, supplies or equipment already paid for by Medicaid - Double billing/Over billing | 6/14/2010 | 1 | $0.00 | 900 |
| | 8/22/2011 | 1 | $0.00 | 466 |
| | 10/3/2011 | 3 | $0.00 | 424 |
| | 10/10/2011 | 1 | $0.00 | 417 |
| | 5/29/2012 | 1 | $0.00 | 185 |
| | 10/24/2012 | 1 | $0.00 | 37 |
| | 11/27/2012 | 1 | $0.00 | 3 |
| | 11/30/2012 | 1 | $0.00 | 0 |

**Exhibit 3**

| | | | | |
|---|---|---|---|---|
| Underutilization of services, quality of care | 5/6/2009 | 1 | $0.00 | 1304 |
| | 10/14/2010 | 1 | $0.00 | 778 |
| Kickbacks/Rebates | 2/22/2010 | 1 | $0.00 | 1012 |
| | 6/4/2012 | 1 | $0.00 | 179 |
| Altering Claim/Bill/Falsifying Records/Documents | 4/26/2010 | 1 | $0.00 | 949 |
| | 6/10/2011 | 1 | $0.00 | 539 |
| Balance Billing Patient | 6/22/2009 | 1 | $0.00 | 1257 |
| | 1/3/2012 | 1 | $0.00 | 332 |
| | 5/23/2012 | 1 | $0.00 | 191 |
| | 6/25/2012 | 1 | $0.00 | 158 |
| | 9/10/2012 | 1 | $0.00 | 81 |
| | 9/28/2012 | 1 | $0.00 | 63 |
| | 10/3/2012 | 1 | $0.00 | 58 |
| | 10/30/2012 | 1 | $0.00 | 31 |
| Forgery | 8/3/2010 | 1 | $0.00 | 850 |
| | 9/24/2010 | 1 | $0.00 | 798 |
| | 10/11/2010 | 1 | $0.00 | 781 |
| | 1/27/2011 | 1 | $0.00 | 673 |
| Provider over prescribing/prescription fraud | 3/13/2012 | 1 | $0.00 | 262 |
| | 9/26/2012 | 1 | $0.00 | 65 |
| Improper/Inappropriate billing practices (i.e. misuse of modifier) | 11/27/2012 | 1 | $0.00 | 3 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 9/11/2008 | 1 | $6,700.00 | 1541 |
| | 1/27/2009 | 1 | $742.00 | 1403 |
| | 2/9/2009 | 1 | $19,238.00 | 1390 |
| | 3/1/2009 | 1 | $0.00 | 1370 |
| | 11/5/2009 | 1 | $0.00 | 1121 |
| | 1/27/2010 | 2 | $0.00 | 1038 |
| | 2/22/2010 | 1 | $0.00 | 1012 |
| | 9/12/2010 | 1 | $0.00 | 810 |
| | 11/3/2010 | 1 | $0.00 | 758 |
| | 2/8/2011 | 1 | $0.00 | 661 |
| | 3/14/2011 | 1 | $0.00 | 627 |
| | 4/8/2011 | 1 | $0.00 | 602 |
| | 4/25/2011 | 1 | $0.00 | 585 |
| | 4/26/2011 | 1 | $0.00 | 584 |
| | 5/2/2011 | 1 | $0.00 | 578 |
| | 7/3/2011 | 1 | $0.00 | 516 |
| | 8/5/2011 | 1 | $0.00 | 483 |
| | 8/11/2011 | 1 | $0.00 | 477 |
| | 11/17/2011 | 1 | $0.00 | 379 |
| | 12/27/2011 | 1 | $0.00 | 339 |
| | 1/18/2012 | 1 | $0.00 | 317 |
| | 2/2/2012 | 2 | $0.00 | 302 |
| | 2/21/2012 | 1 | $0.00 | 283 |
| | 3/1/2012 | 1 | $0.00 | 274 |
| | 3/2/2012 | 1 | $0.00 | 273 |
| | 4/3/2012 | 1 | $0.00 | 241 |
| | 4/9/2012 | 1 | $0.00 | 235 |
| | 4/13/2012 | 1 | $0.00 | 231 |
| | 4/18/2012 | 1 | $0.00 | 226 |
| | 4/30/2012 | 1 | $0.00 | 214 |
| | 7/2/2012 | 1 | $0.00 | 151 |
| | 7/19/2012 | 2 | $0.00 | 134 |
| | 7/22/2012 | 3 | $0.00 | 131 |
| | 7/24/2012 | 2 | $0.00 | 129 |
| | 7/25/2012 | 2 | $0.00 | 128 |
| | 7/27/2012 | 1 | $0.00 | 126 |
| | 8/7/2012 | 1 | $0.00 | 115 |
| | 8/9/2012 | 2 | $0.00 | 113 |
| | 8/13/2012 | 3 | $0.00 | 109 |
| | 8/14/2012 | 1 | $0.00 | 108 |
| | 8/22/2012 | 1 | $0.00 | 100 |

| | | | | |
|---|---|---|---|---|
| | 8/28/2012 | 1 | $0.00 | 94 |
| | 9/17/2012 | 1 | $0.00 | 74 |
| | 9/27/2012 | 1 | $0.00 | 64 |
| | 9/28/2012 | 4 | $0.00 | 63 |
| | 10/9/2012 | 1 | $0.00 | 52 |
| | 10/11/2012 | 1 | $0.00 | 50 |
| | 10/15/2012 | 2 | $0.00 | 46 |
| | 10/19/2012 | 1 | $0.00 | 42 |
| | 10/26/2012 | 2 | $0.00 | 35 |
| | 10/30/2012 | 1 | $0.00 | 31 |
| | 11/6/2012 | 1 | $0.00 | 24 |
| | 11/7/2012 | 1 | $0.00 | 23 |
| | 11/9/2012 | 1 | $0.00 | 21 |
| | 11/15/2012 | 2 | $0.00 | 15 |
| | 11/20/2012 | 4 | $0.00 | 10 |
| | 11/26/2012 | 2 | $0.00 | 4 |
| | 11/27/2012 | 1 | $0.00 | 3 |
| | 11/28/2012 | 3 | $0.00 | 2 |
| Pharmacy provides less than the prescribed quantity and intentionally does not inform the patient but bills for the full amount (i.e., billing for 60 tablets, but only dispensing 30) | 9/17/2010 | 1 | $0.00 | 805 |
| | 8/16/2011 | 1 | $0.00 | 472 |
| | 6/12/2012 | 1 | $0.00 | 171 |
| Pharmacy waives copays to entice members to use that store | 1/21/2009 | 1 | $158,106.00 | 1409 |
| Self-Referral | 9/23/2011 | 1 | $0.00 | 434 |
| Provider allegedly improperly disposed of members medical records. | 1/11/2010 | 1 | $0.00 | 1054 |
| | 8/10/2010 | 1 | $0.00 | 843 |
| | 5/12/2011 | 1 | $0.00 | 568 |
| | 7/7/2011 | 1 | $0.00 | 512 |
| | 8/22/2011 | 1 | $0.00 | 466 |
| | 8/29/2011 | 1 | $0.00 | 459 |
| | 8/30/2011 | 5 | $0.00 | 458 |
| | 9/1/2011 | 1 | $0.00 | 456 |
| | 10/6/2011 | 1 | $0.00 | 421 |
| | 10/13/2011 | 1 | $0.00 | 414 |
| | 11/9/2011 | 3 | $0.00 | 387 |
| | 11/22/2011 | 1 | $0.00 | 374 |
| | 12/21/2011 | 1 | $0.00 | 345 |
| | 3/13/2012 | 4 | $0.00 | 262 |
| | 3/20/2012 | 1 | $0.00 | 255 |
| | 4/18/2012 | 1 | $0.00 | 226 |
| | 5/7/2012 | 1 | $0.00 | 207 |
| | 5/14/2012 | 1 | $0.00 | 200 |
| | 5/21/2012 | 1 | $0.00 | 193 |
| | 5/30/2012 | 1 | $0.00 | 184 |
| | 6/18/2012 | 1 | $0.00 | 165 |
| | 7/2/2012 | 1 | $0.00 | 151 |
| | 7/19/2012 | 2 | $0.00 | 134 |
| | 8/27/2012 | 3 | $0.00 | 95 |
| | 9/5/2012 | 1 | $0.00 | 86 |
| | 9/13/2012 | 1 | $0.00 | 78 |
| | 9/25/2012 | 1 | $0.00 | 66 |
| | 9/28/2012 | 4 | $0.00 | 63 |
| Subcontractor/Vendor Complaint | 11/18/2010 | 1 | $0.00 | 743 |
| | 6/14/2012 | 1 | $0.00 | 169 |
| | 9/4/2012 | 2 | $0.00 | 87 |
| | 9/11/2012 | 1 | $0.00 | 80 |
| | 9/24/2012 | 1 | $0.00 | 67 |
| | 9/26/2012 | 2 | $0.00 | 65 |
| | 9/30/2012 | 3 | $0.00 | 61 |

**Exhibit 3**

| | | | | |
|---|---|---|---|---|
| Other | 10/4/2012 | 1 | $0.00 | 57 |
| | 10/23/2012 | 1 | $0.00 | 38 |
| | 10/25/2012 | 2 | $0.00 | 36 |
| | 10/30/2012 | 2 | $0.00 | 31 |
| | 11/9/2012 | 2 | $0.00 | 21 |
| | 11/12/2012 | 1 | $0.00 | 18 |
| | 11/15/2012 | 2 | $0.00 | 15 |
| | 11/16/2012 | 1 | $0.00 | 14 |
| | 11/19/2012 | 4 | $0.00 | 11 |
| | 11/20/2012 | 5 | $0.00 | 10 |
| | 11/26/2012 | 2 | $0.00 | 4 |
| | 11/27/2012 | 5 | $0.00 | 3 |
| | 11/28/2012 | 1 | $0.00 | 2 |
| | 11/29/2012 | 2 | $0.00 | 1 |
| | 11/30/2012 | 5 | $0.00 | 0 |
| Blank | 10/2/2012 | 5 | $0.00 | 59 |
| | 10/3/2012 | 1 | $0.00 | 58 |
| | 10/7/2012 | 2 | $0.00 | 54 |
| | 10/11/2012 | 1 | $0.00 | 50 |
| | 10/15/2012 | 1 | $0.00 | 46 |
| | 10/17/2012 | 2 | $0.00 | 44 |
| | 10/22/2012 | 2 | $0.00 | 39 |
| | 11/2/2012 | 2 | $0.00 | 28 |
| | 11/19/2012 | 5 | $0.00 | 11 |
| | 11/21/2012 | 4 | $0.00 | 9 |
| | 11/25/2012 | 2 | $0.00 | 5 |
| Providing services, supplies, or equipment that are not medically necessary | 2/5/2008 | 1 | $109,597.00 | 1760 |
| | 4/15/2008 | 1 | $44,635.00 | 1690 |
| | 10/14/2008 | 1 | $28,942.36 | 1508 |
| | 1/27/2011 | 1 | $0.00 | 673 |
| | 2/28/2011 | 1 | $0.00 | 641 |
| | 6/23/2011 | 1 | $0.00 | 526 |
| | 7/1/2011 | 1 | $0.00 | 518 |
| | 8/29/2011 | 2 | $0.00 | 459 |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 10/12/2009 | 1 | $0.00 | 1145 |
| | 4/21/2010 | 7 | $6,262.00 | 954 |
| | 5/24/2010 | 1 | $0.00 | 921 |
| | 6/15/2010 | 1 | $0.00 | 899 |
| | 7/13/2010 | 1 | $0.00 | 871 |
| | 12/7/2010 | 1 | $0.00 | 724 |
| | 1/20/2011 | 1 | $0.00 | 680 |
| | 2/8/2011 | 1 | $0.00 | 661 |
| | 2/28/2011 | 1 | $0.00 | 641 |
| | 7/14/2011 | 1 | $0.00 | 505 |
| | 3/7/2012 | 1 | $50,847.78 | 268 |
| | 3/13/2012 | 1 | $0.00 | 262 |
| Upcoding the level of service provided | 1/14/2008 | 1 | $80,006.00 | 1782 |
| | 6/10/2008 | 1 | $10,972.00 | 1634 |
| | 6/11/2008 | 1 | $21,801.00 | 1633 |
| | 5/15/2009 | 1 | $0.00 | 1295 |
| | 5/18/2009 | 1 | $68,326.78 | 1292 |
| | 9/9/2009 | 1 | $0.00 | 1178 |
| | 10/9/2009 | 2 | $0.00 | 1148 |
| | 1/28/2010 | 1 | $0.00 | 1037 |
| | 2/10/2010 | 1 | $28,129.10 | 1024 |
| | 2/25/2010 | 1 | $0.00 | 1009 |
| | 3/18/2010 | 1 | $13,657.63 | 988 |
| | 8/25/2010 | 1 | $0.00 | 828 |
| | 5/18/2011 | 3 | $116,163.05 | 562 |
| | 5/31/2011 | 2 | $0.00 | 549 |
| | 8/22/2011 | 2 | $0.00 | 466 |
| | 3/8/2012 | 1 | $0.00 | 267 |
| | 6/15/2012 | 13 | $0.00 | 168 |
| | 11/7/2012 | 7 | $0.00 | 23 |

| | | | | |
|---|---|---|---|---|
| Unbundling a global or all-inclusive fee | 8/22/2011 | 1 | $0.00 | 466 |
| | 8/30/2011 | 1 | $0.00 | 458 |
| Overutilization-excessive services, billing contract limit | 7/28/2008 | 1 | $23,494.00 | 1586 |
| | 6/7/2011 | 1 | $0.00 | 542 |
| | 7/2/2012 | 1 | $0.00 | 151 |
| | 9/13/2012 | 1 | $0.00 | 78 |
| | 9/20/2012 | 1 | $0.00 | 71 |
| | 11/5/2012 | 1 | $0.00 | 25 |

| **Magellan** | | | | |
|---|---|---|---|---|
| **Potential F&A Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Length of Time on Report (Calendar days)** |
| Altering Claim/Bill/Falsifying Records/Documents | 1/28/2011 | 1 | $24,875.74 | 672 |
| Balance Billing Patient | 5/29/2012 | 1 | $292.00 | 185 |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 2/15/2012 | 1 | $310.00 | 289 |
| | 7/13/2012 | 1 | $62.46 | 140 |
| | 7/27/2012 | 1 | $106.00 | 126 |
| Billing History | 7/12/2012 | 2 | $0.00 | 141 |
| Upcoding the level of service provided | 2/3/2012 | 1 | $372.00 | 301 |
| Unbundling a global or all-inclusive fee | 4/20/2012 | 1 | $75,000.00 | 224 |
| **Grand Total** | | **365** | **$905,041.90** | |

**Exhibit 3**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 5: Closed Cases/Leads as of 11/30/2012**

| CMO/Subcontractor | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| WellCare | 306 | $193,748.00 |
| Avesis | 1 | $27,790.72 |
| DentaQuest | 11 | $23,757.13 |
| Magellan | 41 | $1,871,673.88 |
| **Grand Total** | **359** | **$2,116,969.73** |

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 6: Open Cases/Leads Missing from Report as of November 2012**

| WellCare | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Prescription Drug Diversion, Misuse and Addiction | 12/9/2011 | 1 | $0.00 | No activity for this month |
| Fraud | 4/9/2012 | 1 | $0.00 | No activity for this month |
| | 4/23/2012 | 1 | $0.00 | No activity for this month |
| | 4/30/2012 | 1 | $0.00 | No activity for this month |
| | 5/1/2012 | 1 | $0.00 | No activity for this month |
| Balance Billing Patient | 4/9/2012 | 1 | $0.00 | No activity for this month |
| Forgery | 9/9/2011 | 1 | $0.00 | No activity for this month |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 12/9/2010 | 1 | $0.00 | No activity for this month |
| | 4/24/2012 | 1 | $0.00 | No activity for this month |
| | 6/18/2012 | 1 | $0.00 | No activity for this month |
| | 7/24/2012 | 1 | $0.00 | No activity for this month |
| | 9/28/2012 | 1 | $0.00 | No activity for this month |
| Self-Referral | 11/15/2011 | 1 | $0.00 | No activity for this month |
| | 1/26/2012 | 3 | $0.00 | No activity for this month |
| | 3/28/2012 | 1 | $0.00 | No activity for this month |
| | 3/30/2012 | 1 | $0.00 | No activity for this month |
| | 5/25/2012 | 1 | $0.00 | Investigator Review: Claims extract generated; Investigator Review: Due diligence collected |
| Immediate close | 5/4/2012 | 1 | $0.00 | No activity for this month |
| | 5/8/2012 | 1 | $0.00 | No activity for this month |
| | 5/10/2012 | 1 | $0.00 | No activity for this month |
| Provider allegedly improperly disposed of members medical records. | 1/15/2010 | 1 | $4,298.00 | No activity for this month |
| | 3/13/2012 | 1 | $0.00 | Other |
| | 3/30/2012 | 1 | $0.00 | No activity for this month |
| | 4/9/2012 | 3 | $0.00 | No activity for this month |
| | 6/28/2012 | 1 | $0.00 | No activity for this month |
| | 7/22/2012 | 1 | $0.00 | No activity for this month |
| | 7/23/2012 | 1 | $0.00 | No activity for this month |
| | 7/26/2012 | 1 | $0.00 | No activity for this month |
| | 8/2/2012 | 1 | $0.00 | No activity for this month |
| | 8/21/2012 | 1 | $0.00 | No activity for this month |
| | 9/10/2012 | 1 | $0.00 | No activity for this month |
| | 9/28/2012 | 7 | $0.00 | No activity for this month |
| Subcontractor/Vendor Complaint | 7/27/2012 | 1 | $0.00 | No activity for this month |
| | 9/26/2012 | 1 | $0.00 | No activity for this month |
| | 9/30/2012 | 2 | $0.00 | No activity for this month |
| Providing services, supplies, or equipment that are not medically necessary | 5/3/2011 | 1 | $0.00 | No activity for this month |
| | 5/5/2011 | 1 | $0.00 | No activity for this month |
| Provider not enrolled/ unlicensed/ misrepresentation of Credentials/services outside of scope of practice | 12/14/2009 | 1 | $0.00 | Investigator Review: Claims extract generated; Other |
| Upcoding the level of service provided | 9/29/2008 | 1 | $5,021.00 | Investigator Review: Submit for approval for external referral |

**Exhibit 3**

| DentaQuest | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Provider over prescribing/prescription fraud | 5/25/2012 | 1 | $0.00 | Clinical audit in review |
| Upcoding the level of service provided | 9/13/2011 | 1 | $0.00 | Placed in Dental Director's agenda for completion. |
| | 1/30/2012 | 1 | $0.00 | Case was taken to the Peer Review Committee. Letter will come from the committee. |
| Overutilization-excessive services, billing contract limit | 5/25/2012 | 1 | $0.00 | Clinical audit in review |

| Magellan | | | | |
|---|---|---|---|---|
| **Potential Fraud or Abuse Issue** | **Date of Complaint** | **Number of Cases** | **Approximate Dollars Involved** | **Results** |
| Balance Billing Patient | 5/29/2012 | 1 | $292.00 | None at this time |
| Billing for services, supplies, or equipment not rendered; unnecessary services | 3/1/2012 | 1 | $106.00 | None at this time |
| Overutilization-excessive services, billing contract limit | 9/15/2009 | 1 | $636.00 | This may generate an additional overpayment of + $42,000.00. |

| | | | |
|---|---|---|---|
| **Grand Total** | **57** | **$20,706.00** | |

**Exhibit 3**

**Georgia Department of Community Health**
**Fraud and Abuse Report Monitoring Analysis**
**Analysis Period: January 1st - November 30th 2012 - WellCare**

**Table 7: Case Referrals**

| Referral Source | Number of Cases | Approximate Dollars Involved |
|---|---|---|
| **WellCare** | | |
| DCH | 115 | $670,679.92 |
| HHS-OIG | 3 | $193,038.00 |
| MEDIC | 10 | $73,347.78 |
| None at this time | 584 | $70,025.00 |
| **Avesis** | | |
| CMO's | 1 | $27,790.72 |
| **DentaQuest** | | |
| WellCare | 10 | $23,757.13 |
| Internal PQAC committee, WellCare | 1 | $0.00 |
| None at this time | 4 | $0.00 |
| **Magellan** | | |
| MFCU | 48 | $1,973,426.62 |
| WellCare, GA | 5 | $299.46 |
| **Grand Total** | **781** | **$3,032,364.63** |

**Fraud and Abuse Reporting Performance Metrics**
**Report Date:**
**Report Period:**
**Report Frequency: QUARTERLY**

**Please enter data *(numeric or dollar value)* in the shaded area .**

| A. Number of CMO/Contractor cases opened during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | |
| Outpatient care: | |
| Physician services: | |
| Pharmacy: | |
| Dental: | |
| Vision: | |
| Durable Medical Equipment: | |
| Behavioral Health: | |
| Laboratory and/or X-ray: | |
| Therapy Services: | |
| Home Health: | |
| All other provider types: | |

| B. Number of CMO/Contractor cases closed during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | |
| Outpatient care: | |
| Physician services: | |
| Pharmacy: | |
| Dental: | |
| Vision: | |
| Durable Medical Equipment: | |
| Behavioral Health: | |
| Laboratory and/or X-ray: | |
| Therapy Services: | |
| Home Health: | |
| All other provider types: | |

| C. Number of CMO/Contractor cases pending during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | |
| Outpatient care: | |
| Physician services: | |
| Pharmacy: | |
| Dental: | |
| Vision: | |
| Durable Medical Equipment: | |
| Behavioral Health: | |
| Laboratory and/or X-ray: | |
| Therapy Services: | |
| Home Health: | |
| All other provider types: | |

| D. Number of CMO/Contractor audits completed during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | |
| Outpatient care: | |
| Physician services: | |
| Pharmacy: | |
| Dental: | |
| Vision: | |
| Durable Medical Equipment: | |
| Behavioral Health: | |
| Laboratory and/or X-ray: | |
| Therapy Services: | |
| Home Health: | |
| All other provider types: | |

| E. Total number of CMO/Contractor audits completed during the reporting period: | |
|---|---|

| F. Total number of claims audited by CMO/Contractor during this reporting period: | |
|---|---|

| G. Dollar value of overpayments identified by CMO/Contractor during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | $ |
| Outpatient care: | $ |
| Physician services: | $ |
| Pharmacy: | $ |
| Dental: | $ |
| Vision: | $ |
| Durable Medical Equipment: | $ |
| Behavioral Health: | $ |
| Laboratory and/or X-ray: | $ |
| Therapy Services: | $ |
| Home Health: | $ |
| All other provider types: | $ |

| H. Total dollar value of overpayments identified by CMO/Contractor during the reporting period: | $ |
|---|---|

| I. Total number of overpayment notifications made during this reporting period as a result of CMO/Contractor audits: | |
|---|---|

| J. Dollar value of CMO/Contractor identified overpayments recovered during the reporting period, by provider type: | |
|---|---|
| Inpatient care: | $ |
| Outpatient care: | $ |
| Physician services: | $ |
| Pharmacy: | $ |
| Dental: | $ |
| Vision: | $ |
| Durable Medical Equipment: | $ |
| Behavioral Health: | $ |
| Laboratory and/or X-ray: | $ |
| Therapy Services: | $ |
| Home Health: | $ |
| All other provider types: | $ |

| | |
|---|---|
| K. Total dollar value of CMO/Contractor identified overpayments recovered during the reporting period: | $ |
| L. Total number of CMO/Contractor determinations for which an appeal was filed during the reporting period: | |
| M. Total dollar amount associated with appeals filed during the reporting period: | $ |
| N. Total number of appeals determinations that were decided in the provider's favor: | |
| O. Total dollar amount that was overturned on appeal during the reporting period: | $ |

**Fraud and Abuse Reporting Performance Metrics - Instructions**

**Please complete the Fraud and Abuse Reporting Performance Metrics using the instructions below (where applicable).**

**D. Number of Contractor audits completed during the reporting period, by provider type:**
(Report Program Integrity audits as "complete" only if the provider has been notified of the audit results – such as the issuance of a demand letter, and/or notification that no demand letter will be issued)

**F. Total number of claims audited by Contractor during this reporting period:**
(Report only claims for which the respective Contractor audit was completed during this reporting period.)

**G. Dollar value of overpayments identified by Contractor during the reporting period, by provider type:**
(The amount "identified" by any Contractor should equal the amount that appears in the overpayment letter submitted to the provider.)

**I. Total number of overpayment notifications made during this reporting period as a result of Contractor audits:**
(This number should reflect the number of overpayment letters that were issued to Program Integrity-audited providers.)

**J. Dollar value of Contractor identified overpayments recovered during the reporting period, by provider type:**
(The amounts "recovered" should reflect dollars that were received by the State.)

**L. Total number of Contractor determinations for which an appeal was filed during this reporting period:**
(Do not double-count any determinations that are appealed at more than one level within the State's appeal process. Any determination that was appealed on at least the first level should be categorized as an appeal.)

**N. Total number of appeals determinations that were decided in the provider's favor:**
(Report only the appeals that were decided during this reporting period.)

**O. Total dollar amount that was overturned on appeal during the reporting period:**
(Report all dollars that were overturned on appeal during this reporting period, regardless of whether the initial appeal was filed during this reporting period or during a previous reporting period.)