

**TITLE 8            SOCIAL SERVICES**  
**CHAPTER 308    MANAGED CARE PROGRAM**  
**PART 22         FRAUD, WASTE AND ABUSE**

**8.308.22.1        ISSUING AGENCY:** New Mexico Health Care Authority.  
[8.308.22.1 NMAC - N, 1/1/2014; A, 7/1/2024]

**8.308.22.2        SCOPE:** This rule applies to the general public.  
[8.308.22.2 NMAC - N, 1/1/2014]

**8.308.22.3        STATUTORY AUTHORITY:** The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.  
[8.308.22.3 NMAC - N, 1/1/2014; A, 7/1/2024]

**8.308.22.4        DURATION:** Permanent.  
[8.308.22.4 NMAC - N, 1/1/2014]

**8.308.22.5        EFFECTIVE DATE:** January 1, 2014, unless a later date is cited at the end of a section.  
[8.308.22.5 NMAC - N, 1/1/2014]

**8.308.22.6        OBJECTIVE:** The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.  
[8.308.22.6 NMAC - N, 1/1/2014]

**8.308.22.7        DEFINITIONS:**

**A.** "Abuse" is provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in unnecessary costs to the medicaid program, or in reimbursement of services that fail to meet professionally recognized standards for health care.

**B.** "Credible allegation of fraud" means an allegation, which has been verified by the state, from any source, including but not limited to the following:

- (1) fraud hotline complaint;
- (2) claims data mining;
- (3) patterns identified through provider audits;
- (4) civil false claims cases; or
- (5) law enforcement investigations; see 42 CFR 455.2.

**C.** "Fraud" means an intentional deception or misrepresentation by a person or an entity, with knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state statutes, regulations and rules.

**D.** "MFEAD" is the medicaid fraud and elder abuse division of the New Mexico attorney general's office

**E.** "Overpayment" means any funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

**F.** "Provider" means a network provider and non-network provider.

**G.** "Recovery" means money received by HSD or MFEAD for fraud or credible allegations of fraud from a provider.

**H.** "Refund" means money returned by a provider for overpayment(s).

**I.** "Waste" is the overutilization of services or other practices that result in unnecessary costs.

[8.308.22.7 NMAC - N, 1/1/2014]

**8.308.22.8        MISSION STATEMENT:** To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.

**8.308.22.9 FRAUD, WASTE AND ABUSE:** HSD is committed to aggressive prevention, detection, monitoring, and investigation to reduce provider or member fraud, waste and abuse. This rule applies to all individuals and entities participating in or contracting with HSD or a MCO for provision or receipt of medicaid services. If fraud, waste or abuse is discovered, HSD shall seek all remedies available to it under federal and state statutes, regulations, rules.

**A.** Program integrity requirements: the MCO shall have a comprehensive internal program integrity and overpayment prevention program to prevent, detect, preliminarily investigate and report potential and actual program violations including detecting potential overutilization of services, drugs, medical supply items and equipment. The MCO shall:

- (1) be responsible for preventing and identifying overpayments or improper payments made to its providers;
- (2) have specific internal controls for prevention, such as claim edits, prepayment and post-payment reviews, and provider profiling; and
- (3) verify that services are actually provided utilizing “explanation of medicaid benefits” (EOB) notices and performing audits, reviews, and preliminary investigations.

**B.** Investigations and referrals: The MCO shall perform preliminary investigations of alleged fraud. The MCO shall:

- (1) after conducting its preliminary investigation, submit to HSD for review all facts, supporting documentation and evidence of alleged fraud;
- (2) upon request from MFEAD, release its preliminary investigation, including all supporting documentation and evidence to MFEAD and cease its investigation until otherwise advised by HSD or MFEAD;
- (3) upon receipt of notification by HSD, and as directed, impose a suspension of payments to providers pending investigations of credible allegations of fraud and non release the payment suspension until notified in writing by HSD.

**C.** Overpayments: Are funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

- (1) An overpayment shall be deemed to have been identified by a provider when:
  - (a) the provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursements;
  - (b) the provider learns that a recipient’s death occurred prior to the service date on which a claim that has been submitted for payment;
  - (c) the provider learns that services were provided by an unlicensed or excluded individual on its behalf;
  - (d) the provider performs an internal audit and discovers that an overpayment exists;
  - (e) the provider is informed by a governmental agency or its designee of an audit that discovered a potential overpayment;
  - (f) the provider is informed by the MCO of an audit that discovered a potential overpayment;
  - (g) the provider experiences a significant increase in medicaid revenue and there is no apparent reason for the increase, such as a new partner added to a group practice or new focus on a particular area of medicine;
  - (h) the provider has been notified that the MCO or a governmental agency or its designee has received a hotline call or email; or
  - (i) the provider has been notified that the MCO or a governmental agency or its designee has received information alleging that a member had not received services or been supplied goods for which the provider submitted a claim for payment.
- (2) The MCO shall require its contracted providers to report to their MCO by the later of:
  - (a) the date which is 60 calendar days after the date on which the overpayment was identified; or
  - (b) the date any corresponding cost report is due, if applicable;

**(3)** The MCO shall require its providers to complete a self-report of the overpayment within 60 calendar days from the date on which the provider identifies an overpayment and require that the provider send an “overpayment report” to the MCO and HSD which includes:

- (a)** the provider’s name;
- (b)** the provider’s tax identification number and national provider number;
- (c)** how the overpayment was discovered;
- (d)** the reason(s) for the overpayment;
- (e)** the health insurance claim number, as appropriate;
- (f)** the date(s) of service;
- (g)** the medicaid claim control number, as appropriate;
- (h)** the description of a corrective action plan to ensure the overpayment does not

occur again;

**(i)** whether the provider has a corporate integrity agreement (CIA) with the United States department of health and human services (HHS) office of inspector general (OIG) or is under the HHS/OIG self-disclosure protocol;

**(j)** the specific dates (or time span) within which the problem existed that caused the overpayments;

**(k)** whether a statistical sample was used to determine the overpayment amount and, if so, a description of the statistically valid methodology used to determine the overpayment; and

- (l)** the refund amount;

**(4)** The MCO shall notify its providers of the provision that overpayments identified by a provider but not self-reported by a provider within the 60-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud;

**(5)** The MCO shall report claims identified for overpayment recovery:  
**(a)** in a format requested by HSD; and  
**(b)** make 837 encounter adjustments with an identifier specified by HSD for recoveries identified by a governmental entity or its designee.

**(6)** Provide all records pertaining to overpayment recovery efforts as requested by HSD.

**D.** Refunds of overpayments:

**(1)** All self-reported refunds for overpayments shall be made by the provider to his or her MCO and are property of the MCO, unless:

- (a)** a governmental entity or its designee independently notified the provider that an overpayment existed; or
- (b)** the MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim;
- (c)** the MCO fails to complete the recovery within 15 months from the date it first paid the claim; or
- (d)** provisions in the HSD agreement with the MCO otherwise provide for all or part of the recovery to go to MAD or HSD.

**(2)** In situations where the MCO and a governmental entity, or its designee, jointly audit its provider, the MCO and the governmental entity or designee shall agree upon a distribution of any refund.

**(3)** Unless otherwise agreed to by the MCO and HSD, the MCO shall not be entitled to any refund or recovery if the refund or recovery is part of a resolution of a state or federal investigation, lawsuit, including but not limited to False Claims Act cases.

**E.** Member fraud, abuse and overutilization:

**(1)** Cases involving one or more of the following situations constitute sufficient grounds for a member fraud referral:

**(a)** the misrepresentation of facts in order to become or to remain eligible to receive benefits under New Mexico medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

**(b)** the transferring by a member of a medicaid member identification (ID) card to a person not eligible to receive services under New Mexico medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

**(c)** the unauthorized use of a medicaid member ID card by a person not eligible to receive medical benefits under a medical assistance program or is a high utilizer of services without apparent medical justification.

(2) HSD and the MCO shall possess the authority to restrict or lock-in a member to a specified and limited number of providers if he or she is involved in potential fraudulent activities or is identified as abusing services provided under his or her medicaid program.

(a) Prior to placing a member on a provider lock-in, the MCO shall inform him or her of the intent to lock-in, including the reasons for imposing the provider lock-in.

(b) The restriction does not apply to emergency services furnished to this member.

(c) The MCO's grievance procedure shall be made available to the member disagreeing with the provider lock-in.

(d) The member shall be removed from provider lock-in when his or her MCO has determined that the member's utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable.

(e) HSD shall be notified of provider lock-ins and provider lock-in removals.

[8.308.22.9 NMAC - N, 1/1/2014]

**HISTORY OF 8.308.22 NMAC:** [RESERVED]