GUIDANCE DOCUMENT FOR

MICHIGAN MEDICAID HEALTH PLANS'

QUARTERLY SUBMISSIONS OF

PROGRAM INTEGRITY ACTIVITIES TO

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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INTRODUCTION:

The Michigan Department of Health and Human Services (MDHHS) is the single state agency responsible for administering the Medicaid Program in the State of Michigan. The MDHHS Medical Services Administration Managed Care Plan Division contracts with health insurance plans (plans) to manage the health needs of Medicaid members. The Managed Plan Care Division ensures plans comply with their contract obligations. The MDHHS Office of Inspector General (OIG) monitors plan compliance with the Program Integrity requirements of their contract.

Michigan Medicaid (including Healthy Michigan and MIChild) Program Integrity activities are reported quarterly by the plans. The quarterly submissions are provided utilizing an Excel workbook created and maintained by MDHHS OIG. The workbook has multiple tabs (worksheets), the first two of which offer instructions and examples to assist the plans in properly completing the workbook. These tab names begin with "Ex." The remaining workbook tabs are discussed below.

This document was developed to provide guidance on the submission requirements and the information to be included (or excluded).

Quarterly submissions from the plans do not negate the contract requirement that plans refer suspected fraud to MDHHS OIG. These referrals may result in preliminary investigations being performed by the MDHHS OIG and may result in referral from MDHHS OIG to the Attorney General Medicaid Fraud Control Unit (AG MFCU) if potential Medicaid provider fraud is found.

Please note:

- ✓ When completing the quarterly submissions, use the **National Provider Identifier (NPI)** for providers; do not use internal identifiers.
- ✓ When completing the quarterly submissions, use the **Medicaid ID** for members; do not use internal identifiers.
- ✓ When completing the quarterly submissions, only report the cases that pertain to Michigan Medicaid providers, members, and dollars.
- ✓ Submissions must be returned in the original format provided by MDHHS OIG and not altered in any way, including changing the submissions to a .pdf document, removing any pre-set filters, adding or removing any rows or columns, or editing any row or column designations.

Program Integrity Report

The **Program Integrity Report** tab summarizes the Program Integrity activities conducted or performed by the plan in the designated Reporting Period. Counts and totals are auto-calculated from the information provided on the **Activities**, **Data Mining Alg Applied**, and **Disenrollments** tabs. The formulas require dates to be a numeral value (formatted as a date) and will not include dates that are formatted as text. The formulas sum items by line and do not account for unique case numbers. The plan will need to verify that counts reported are accurate; if the report does not reflect the information included on the other tabs, correction will be required. Explanation of Benefits (EOBs) Sent to Members is manually entered.

Items to Complete:

- **Health Plan Name** – Self-explanatory.
- **Reporting Period** – The time period during which Program Integrity activities were performed. Choose the applicable time period from the dropdown box; choices are Oct-Dec, Jan-Mar, Apr-Jun, and Jul-Sep.
- **Calendar Year** – The calendar year during which Program Integrity activities were performed. Choose the applicable calendar year from the dropdown box.
- **Submission Version** – Indicate the version being submitted (e.g. "1st Sub" for first/initial submission, "2nd Sub" for second submission, "CAP" for correction/corrective action plan).
- **Submission Date** – Date report submitted.

The tab has six components: 6.1 Tips and Grievances, 6.2 Data Mining/Algorithms, 6.3 Audits, 6.4 Provider Disenrollments, 6.5 Overpayments, and 6.6 Explanation of Benefits (EOBs) Sent to Members.

6.1 Tips and Grievances – Complaints or referrals received by the plan from members, providers, or other entities (including, but not limited to, employees of providers, employees of the plan, the general public, etc.) relating to Program Integrity that require investigation to address the issue reported.

Items to Complete:

- ✓ **Number of tips and/or grievances received** – Total number of Michigan Medicaid complaints or referrals received by the plan during the Reporting Period that relate to Program Integrity; differentiate between complaints/referrals related to **providers** or their employees or contractors, those related to **members**, and those related to **others** (individuals or entities that are the target of a complaint, but are not providers or employees or contractors of a provider and are not members). Audit referrals from MDHHS OIG should be listed under Audit activities, not Tips and Grievances.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Tip or Grievance"
    - **D:** DATE INITIATED = in the current Reporting Period
    - **E:** TARGET OF ACTIVITY

- ✓ **Number of reviews resolved** – Total number of Michigan Medicaid reviews/cases/ investigations finalized during the Reporting Period (regardless of the date initiated); differentiate between reviews resolved with **providers** as targets, those resolved with **members** as targets, and those resolved with **others** as targets.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Tip or Grievance"
    - **E:** TARGET OF ACTIVITY
    - **AB:** DATE CASE/REVIEW RESOLVED = in the current Reporting Period

- ✓ **Number of reviews that resulted in identification of potential fraud** – Total number of Michigan Medicaid reviews/cases/investigations completed (but not necessarily finalized) during the Reporting Period where potential fraud was identified; differentiate between reviews with **providers** as targets, those with **members** as targets, and those with **others** as targets.
  - Derived from information on the **Activities** tab, Columns:
    B: ACTIVITY TYPE = "Tip or Grievance"
    E: TARGET OF ACTIVITY
    S: DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED = in the current Reporting Period
    T: POTENTIAL FRAUD IDENTIFIED = "Y"

- ✓ **Number referred to MDHHS OIG in the quarter** – Total number of Michigan Medicaid reviews/cases/investigations where potential fraud was identified and the review/case/investigation was referred to MDHHS OIG during the Reporting Period; differentiate between referrals of **providers**, referrals of **members**, and referrals of **others**.
  - Derived from information on the **Activities** tab, Columns:
    B: ACTIVITY TYPE = "Tip or Grievance"
    E: TARGET OF ACTIVITY
    U: DATE REFERRED TO MDHHS OIG = in the current Reporting Period

    Please note that referrals for:
    - ➢ Michigan Medicaid reviews/cases/investigations **related to providers** must be sent to the MDHHS OIG via secure file transfer protocol (sFTP).
    - ➢ Michigan Medicaid reviews/cases/investigations **related to members** must be reported to the MDHHS OIG via online form (**https://mdhhs.michigan.gov/Fraud/**) or the Welfare Fraud Hotline (800-222-8558).
    - ➢ Michigan Medicaid reviews/cases/investigations **related to others** must be sent to the MDHHS OIG via secure file transfer protocol (sFTP).

6.2 Data Mining/Algorithms – Program Integrity scenarios (programs, formulas, queries, etc.) applied to claims data to identify providers or members to review/investigate for potential fraud, waste, or abuse.

Items to Complete:

- ✓ **Number of data mining activities/algorithms applied** – Total number of Program Integrity scenarios applied during the Reporting Period to Michigan Medicaid claims data to identify providers or members for review; differentiate between those applied to identify **providers** and those applied to identify **members**.
  - Derived from information on the **Data Mining Alg Applied** tab, Columns:
    A: DATE DATA MINING ACTIVITY APPLIED TO DATA TO IDENTIFY PROVIDERS OR MEMBERS FOR REVIEW = in the current Reporting Period (do not use date ranges)
    C: TARGET OF ACTIVITY

- ✓ **Number of reviews initiated as a result of those data mining activities/algorithms** – Total number of reviews/cases/investigations initiated as a result of applying Program Integrity scenarios to Michigan Medicaid claims data; differentiate between reviews initiated for **providers** and those initiated for **members**.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Data Mining Alg Review"
    - **D:** DATE INITIATED = in the current Reporting Period
    - **E:** TARGET OF ACTIVITY

- ✓ **Number of reviews resolved** – Total number of Michigan Medicaid reviews/cases/ investigations finalized during the Reporting Period (regardless of the date initiated); differentiate between reviews resolved with **providers** as targets and those resolved with **members** as targets.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Data Mining Alg Review"
    - **E:** TARGET OF ACTIVITY
    - **AB:** DATE CASE/REVIEW RESOLVED = in the current Reporting Period

- ✓ **Number of reviews that resulted in identification of potential fraud** – Total number of Michigan Medicaid reviews/cases/investigations completed (but not necessarily finalized) during the Reporting Period where potential fraud was identified; differentiate between reviews with **providers** as targets and those with **members** as targets.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Data Mining Alg Review"
    - **E:** TARGET OF ACTIVITY
    - **S:** DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED = in the current Reporting Period
    - **T:** POTENTIAL FRAUD IDENTIFIED = "Y"

- ✓ **Number referred to MDHHS OIG in the quarter** – Total number of Michigan Medicaid reviews/cases/investigations where potential fraud was identified and the review/case/investigation was referred to MDHHS OIG during the Reporting Period; differentiate between referrals of **providers** and referrals of **members**.

  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Data Mining Alg Review"
    - **E:** TARGET OF ACTIVITY
    - **U:** DATE REFERRED TO MDHHS OIG = in the current Reporting Period

    Please note:
    - ➢ Michigan Medicaid reviews/cases/investigations **related to providers** must be sent to the MDHHS OIG via secure file transfer protocol (sFTP).

- Michigan Medicaid reviews/cases/investigations **related to members** must be sent to the MDHHS OIG via online (**https://mdhhs.michigan.gov/Fraud/**) or the Welfare Fraud Hotline (800-222-8558).

6.3 Audits – Program Integrity provider audits performed on a scheduled or ad hoc basis, unrelated to reviews/cases/investigations for tips and grievances or data mining activities/algorithms. (This would include any audit referrals from MDHHS OIG.)

Items to Complete:

- ✓ **Number of provider audits initiated** – Total number of Michigan Medicaid provider audits for which work was started during the Reporting Period.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Audit"
    - **E:** TARGET OF ACTIVITY = "Provider"
    - **D:** DATE INITIATED = in the current Reporting Period

- ✓ **Number of provider audits resolved** – Total number of Michigan Medicaid provider audits for which work was finalized during the Reporting Period.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Audit"
    - **E:** TARGET OF ACTIVITY = "Provider"
    - **AB:** DATE CASE/REVIEW RESOLVED = in the current Reporting Period

- ✓ **Number of provider audits resulted in identification of fraud** – Total number of Michigan Medicaid audits that were finalized during the Reporting Period and which revealed potential fraud.
  - Derived from information on the **Activities** tab, Columns:
    - **B:** ACTIVITY TYPE = "Audit"
    - **E:** TARGET OF ACTIVITY = "Provider"
    - **S:** DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED= in the current Reporting Period
    - **T:** POTENTIAL FRAUD IDENTIFIED = "Y"

- ✓ **Number referred to MDHHS OIG** – Total number of Michigan Medicaid provider audits that resulted in referral to the MDHHS OIG via secure file transfer protocol (sFTP) during the Reporting Period.
  - Derived from information on the **Activities** tab, columns
    - **B:** ACTIVITY TYPE = "Audit"
    - **E:** TARGET OF ACTIVITY = "Provider"
    - **U:** DATE REFERRED TO MDHHS OIG = in the current Reporting Period

6.4 Provider Disenrollments – Providers disenrolled by the plan, either for cause or not for cause (such as at the request of the provider).

Please note:

- ✓ DATE DISENROLLMENT PROCESSED must fall within range of the Reporting Period. Counts on the **Program Integrity Report** tab are based on the date the act of disenrolling a provider was completed.
- ✓ EFFECTIVE DATE OF DISENROLLMENT can be retroactive or prospective.
- ✓ Do not count rows with duplicate values for PROVIDER NPI **and** PROVIDER PAY TO ADDRESS; disenrollments with the same NPI **and** same address are counted once. However, multiple disenrollments recorded due to a provider having multiple addresses for a single NPI are counted individually. For example:
  - ➢ Dr. Smith (NPI 1234567890) disenrolled/recorded twice with the same PROVIDER PAY TO ADDRESS = 1 disenrollment reported.
  - ➢ Dr. Jones (NPI 9876543210) disenrolled/recorded twice with two different PROVIDER PAY TO ADDRESS = 2 disenrollments reported.
- Contact information for HHS OIG:
  - ➢ **Tamara Johnson**, Special Agent in Charge, Sanctions and Exclusions, HHS/OIG, Office of Investigations, **tamara.johnson@oig.hhs.gov.**

Items to Complete:

- ✓ **Number of providers disenrolled by the health plan** – Total number of Michigan Medicaid providers disenrolled from the health plan during the Reporting Period.
  - Derived from information on the **Disenrollments** tab, Columns:
    A: DATE DISENROLLMENT PROCESSED = in the current Reporting Period

- ✓ **Number of disenrolled providers reported to HHS OIG with copy to MDHHS OIG** – Total number of Michigan Medicaid providers disenrolled during the Reporting Period for cause and reported HHS-OIG w/copy to MDHHS OIG via the MDHHS OIG via secure file transfer protocol (sFTP).
  - Derived from information on the **Disenrollments** tab, Columns:
    G: DATE REFERRED TO HHS OIG WITH COPY TO MDHHS OIG = in the current Reporting Period

6.5 Overpayments – Instances in which Medicaid dollars are recouped from providers.

Please note:

- ✓ Total amounts reported for identified overpayments and collected overpayments do not reference DATE INITIATED or DATE RESOLVED on the Activities Tab. However, total amount reported for identified overpayments does reference the DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED.

- ✓ It is the plan's responsibility to ensure that all collections reported on the Activities Tab occurred in the reporting period.
- ✓ Amounts for overpayments identified and collected are independent of one another for reporting purposes. These totals serve to report the total amount of overpayments identified when an initial review is completed and the total amount collected in the current reporting period.

Items to Complete:

- ✓ **Total dollar amount of overpayments identified in the quarter** – Total dollar amount of Michigan Medicaid dollars identified as an overpayment.
  - Derived from information on the **Activities** tab, Columns:
    S: DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED = in the current Reporting Period
    W: TOTAL OVERPAYMENT AMOUNT IDENTIFIED RELATED TO ACTIVITY

- ✓ **Total dollar amount of overpayments collected in the quarter** – Total dollar amount of Michigan Medicaid dollars collected for overpayments.
  - Derived from information on the **Activities** tab, Column:
    Z: TOTAL COLLECTION AMOUNT THIS REPORTING PERIOD

6.6. Explanation of Benefits (EOBs) Sent to Members – This area requests the number of explanation of benefit forms (EOBs) sent to members and the number of members for whom services were adjudicated for the Reporting Period. This information is needed to ensure the plan is sending EOBs to at least 5% of their members.

Items to Complete for each month of the Reporting Period:

- ✓ **Number of members for whom claims were adjudicated in MONTH (after exclusions)** – Total number of Michigan Medicaid members for whom services were adjudicated during the applicable month of the Reporting Period.
- ✓ **Number of EOBs sent for MONTH** – Total number of EOBs sent in the applicable month of the Reporting Period.

Activities Tab

The Activities tab provides details of the Michigan Medicaid Program Integrity activities conducted by the plan for the Reporting Period relating to investigation of tips and grievances, review of data mining/algorithms, audits of providers, and any financial recoveries (overpayments) the plan has made in regard to Michigan Medicaid providers.

Columns/fields to be completed are:

A. **UNIQUE CASE NUMBER** – Enter the unique identifier for the activity being performed. This would include investigation of a referral or complaint, review of data mining, provider audit, or financial recoveries (collection of an overpayment).
   - Use "NO CASE NUMBER ASSIGNED" or "N/A" for any activities that did not warrant a unique identifier.

B. **ACTIVITY TYPE** – Choose the appropriate activity type from the dropdown list:
   - Tip or Grievance
   - Data Mining Alg Review
   - Audit
   - Overpayment

C. **SOURCE OF ACTIVITY** – Specify the method by which the referral or complaint was conveyed to the plan. Examples include, but are not limited to:
   - Member via EOB
   - Member via hotline
   - Member via means other than EOB or hotline
   - Provider via hotline
   - Provider via means other than hotline
   - Law enforcement
   - Indictment
   - Internal
   - Desk Audit

D. **DATE INITIATED** – Enter the date the review of the member or provider (or other) began.

E. **TARGET OF ACTIVITY** – Indicate whether the target of the review/case/investigation is a provider, member, or other.

F. **MEMBER ID#** – If the target of the review/case/investigation is a member **OR** if the target of the review/case/investigation is a provider and the complaint/referral originated from a member, enter the Michigan Medicaid member's identification number.
   - Use the Michigan Medicaid identification number. Do not use internal identifiers.

G. **MEMBER NAME** – If the target of the review/case/investigation is a member **OR** if the target of the review/case/investigation is a provider and the complaint/referral originated from a member, enter the Michigan Medicaid member's name.

H. **PROVIDER NPI#** – If the target of the review/case/investigation is a provider **OR** if the target of the review/case/investigation is a member (or other) and the complaint/referral originated from a provider, enter the National Provider Identifier (NPI) of the Michigan Medicaid provider (individual, group, or facility).

I. **PROVIDER NAME** – If the target of the review/case/investigation is a provider **OR** if the target of the review/case/investigation is a member (or other) and the complaint/referral originated from a provider, enter the name of the Michigan Medicaid provider (individual, group, or facility).

J. **PROVIDER TYPE** – If applicable, enter the provider type. Examples include, but are not limited to:
   - Individual
   - Facility

K. **PROVIDER TAXONOMY** – If applicable, enter the provider taxonomy. Examples include, but are not limited to:
   - Internal Medicine
   - DME
   - Pharmacy

L. **PROVIDER ROLE** – If applicable, choose the appropriate provider role from the dropdown list:
   - Rendering
   - Billing
   - Prescribing
   - Referring

M. **TIME PERIOD COVERED (two fields, Columns M & N)** – Indicate the date range for the claims or payments being reviewed. Column M is the first date of time period covered.
   - If the activity in question only encompassed a single date, such as identification of an overpayment on a single claim/DOS, list the date as the first date.

N. **TIME PERIOD COVERED (two fields, Columns M & N)** – Indicate the date range for the claims or payments being reviewed. Column N last date of time period covered.
   - If the activity in question only encompassed a single date, such as identification of an overpayment on a single claim/DOS, list the date as the first date (Column M).

O. **SUMMARY OF COMPLAINT/ACTIVITY** – If ACTIVITY TYPE (Column B) is:
   - Tip or Grievance – Include a brief summary of the complaint.
   - Data Mining Alg Review – Enter a brief description of the billing pattern relating to the data mining activity.
   - Audit – Enter a brief description of the billing pattern relating to the audit activity.
   - Overpayment – A brief summary or description of the overpayment is preferred, but it is acceptable to leave this field blank.

P. **CODES INVOLVED IN COMPLAINT / ACTIVITY** – If applicable, indicate specific procedure codes or other codes reported as potentially aberrant claim lines.

Q. **TOTAL PAID AMOUNT RELATING TO ACTIVITY** – Enter the total dollar amount paid for Michigan Medicaid claims included in your review/case/investigation.

R. **OVERPAYMENT IDENTIFIED** – Indicate whether the review/case/investigation resulted in the identification of an overpayment of Medicaid dollars (“Y” for yes; “N” for no).

S. **DATE INITIAL REVIEW COMPLETED/OVERPAYMENT IDENTIFIED** – Enter the date the initial review was completed or, for overpayment activities, the date the overpayment was identified.
   - This date is not necessarily the same date the review/case/investigation is finalized.

T. **POTENTIAL FRAUD IDENTIFIED** – Indicate whether the case resulted in potential fraud (“Y” for yes; “N” for no).

U. **DATE REFERRED TO MDHHS OIG** – Enter the date the provider was referred to MDHHS OIG.
   - If potential fraud was identified, the provider must be referred to MDHHS OIG. Referrals could also result from frequent complaints or inappropriate conduct.

V. **DATE FINAL NOTICE SENT TO PROVIDER** – If applicable, enter the date the recovery notice, the final determination, was sent to the provider.

- If an overpayment is identified, the provider has a right to appeal initial findings and supply additional documentation to support amounts billed/paid. DATE FINAL NOTICE SENT TO PROVIDER is the final determination of the overpayment amount, initiating the recoupment process.

W. **TOTAL OVERPAYMENT AMOUNT IDENTIFIED RELATED TO ACTIVITY –** If applicable, enter the total amount of Michigan Medicaid dollars that were identified as overpayments.

X. **TOTAL NUMBER OF PAID CLAIMS RELATED TO OVERPAYMENT** – If applicable, enter the total number of Michigan Medicaid claims that included an overpayment amount.

Y. **OPENING BALANCE THIS REPORTING PERIOD** – If applicable, enter the TOTAL OVERPAYMENT AMOUNT IDENTIFIED RELATED TO ACTIVITY **OR** the outstanding balance of the TOTAL OVERPAYMENT AMOUNT IDENTIFIED RELATED TO ACTIVITY owed on the first date of the Reporting Period.
- While it is preferred to have this information, this field is not required for "Overpayment" activity types. If balance information is not available for an "Overpayment" activity, the field must be designated "N/A."

Z. **TOTAL COLLECTION AMOUNT THIS REPORTING PERIOD** – If applicable, enter the total amount of Michigan Medicaid dollars collected as a result of overpayment during the Reporting Period.

AA. **ENDING BALANCE AS OF THE END OF THIS REPORTING PERIOD** – If applicable, enter the balance of the TOTAL OVERPAYMENT AMOUNT IDENTIFIED RELATED TO ACTIVITY owed on the last day of the Reporting Period.
- While it is preferred to have this information, this field is not required for "Overpayment" activity types. If balance information is not available for an "Overpayment" activity, the field must be designated "N/A."

AB. **DATE CASE/REVIEW RESOLVED** – Indicate the date the review/case/investigation was closed.
- If the case has been finalized, include the date it was closed.
- If the CASE STATUS DETAILS (Column AD) indicate that the review/case/investigation is active or pending/on hold, enter "Active" rather than a date.

AC. **SUMMARY OF RESOLUTION / FINDINGS** – If the review/case/investigation was resolved, this field cannot be blank.
- If the case did not result in negative action, enter "No findings."
- If the case resulted in a negative action (e.g., recovery of an overpayment, provider disenrollment, or prospective prepayment review), enter a brief summary of the results of the review/case/investigation.

AD. **CASE STATUS DETAILS** – Indicate the status of the case as of the last date of the Reporting Period. Examples include, but are not limited to:
- In Process/Audit
- Closed – Recovery
- Closed – Provider Disenrolled
- Closed – No Further Action Necessary
- Closed – Potential Fraud, Waste, or Abuse
- Closed – Prospective/Prepayment Review

Data Mining Alg Applied Tab

The **Data Mining Alg Applied** tab lists the data mining/algorithms applied during the designated Reporting Period.

Columns/fields to be completed are:

A. **DATE DATA MINING ACTIVITY APPLIED TO DATA TO IDENTIFY PROVIDERS/MEMBERS FOR REVIEW** – Enter the date that the data mining/algorithm was applied to the Michigan Medicaid claims data in order to identify providers or members for review for potential fraud, waste, or abuse. If the plan employs a vendor to perform data mining activities, the vendor must provide this date. If an activity is applied/run multiple times in a Reporting Period, use the first date of the Reporting Period and include the dates/frequency in the DESCRIPTION OF DATA MINING ACTIVITY APPLIED.

B. **DESCRIPTION OF DATA MINING ACTIVITY APPLIED** – Indicate the data mining algorithm/scenario applied, dates/frequency the algorithm/scenario is applied, and the time period of the claims to which it is applied. "Overpayment" activity types should not be listed as data mining algorithms/scenarios (e.g., providers self-reporting or third-party liability). Examples include, but are not limited to:
   - Upcoding of Services
   - Unbundling
   - Services Billed but Not Rendered
   - Provider Sanctioned for Loss of License or Sanctioned by a Federal Agency
   - Duplicate Billing
   - Billing for Services Not Ordered
   - Services Billed by Unlicensed Providers
   - Services Billed or Prescribed by a Provider Convicted of Fraud
   - Misrepresentation of Services or Diagnoses
   - Falsifying Documents
   - Significant Narcotic Fills
   - Potential Abuse of Emergency Room
   - Doctor Shopping
   - Member Filling Multiple Prescriptions Out of State

C. **TARGET OF ACTIVITY** – Indicate whether the data mining/algorithm is being applied to identify providers or members for review.

Disenrollments Tab

The **Disenrollments** tab provides details of the activities conducted by the plan relating to disenrollments of Michigan Medicaid providers in the designated Reporting Period. All provider disenrollments are to be reported, whether for cause or as a result of provider request.

Columns/fields to be completed are:

A. **DATE DISENROLLMENT PROCESSED** – Enter the date that the disenrollment was processed by the plan.
B. **EFFECTIVE DISENROLLMENT DATE** – Enter the date that the disenrollment became effective with the plan, if different than DATE DISENROLLMENT PROCESSED.
C. **PROVIDER NPI** – Enter the National Provider Identifier of the disenrolled Michigan Medicaid provider (individual, group, or facility).
D. **PROVIDER NAME** – Enter the name of the disenrolled Michigan Medicaid provider.
E. **PROVIDER PAY TO ADDRESS** – Enter the pay to address of the disenrolled Michigan Medicaid provider.
F. **REASON FOR DISENROLLMENT** – Enter a brief explanation of why the provider was disenrolled, including whether it was voluntary by the provider.
G. **DATE REFERRED TO HHS OIG WITH COPY TO MDHHS OIG** – If applicable, enter the date the provider was referred to Health and Human Services (HHS) OIG with a copy to MDHHS OIG.
    - Contact information for HHS OIG:
        - **Tamara Johnson**, Special Agent in Charge, Sanctions and Exclusions, HHS/OIG, Office of Investigations, **tamara.johnson@oig.hhs.gov.**

CONTACT INFORMATION:

Please direct any questions, comments, or concerns regarding the guidance document to MDHHS OIG, **MDHHS-OIG@michigan.gov**.