

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

§ 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

[52 FR 48817, Dec. 28, 1987]

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

- (a) Methods and criteria for identifying suspected fraud cases;
- (b) Methods for investigating these cases that—
 - (1) Do not infringe on the legal rights of persons involved; and
 - (2) Afford due process of law; and
- (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3755, Jan. 27, 1983]

§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

[48 FR 3756, Jan. 27, 1983]

§ 455.15 Full investigation.

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

- (a) If a provider is suspected of fraud or abuse, the agency must—
 - (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title; or
 - (2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State Medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the

case to the appropriate law enforcement agency.

(b) If there is reason to believe that a beneficiary has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a beneficiary has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

[48 FR 3756, Jan. 27, 1983, as amended at 51 FR 34788, Sept. 30, 1986]

§ 455.16 Resolution of full investigation.

A full investigation must continue until—

- (a) Appropriate legal action is initiated;
- (b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
- (c) The matter is resolved between the agency and the provider or beneficiary. This resolution may include but is not limited to—
 - (1) Sending a warning letter to the provider or beneficiary, giving notice that continuation of the activity in question will result in further action;
 - (2) Suspending or terminating the provider from participation in the Medicaid program;
 - (3) Seeking recovery of payments made to the provider; or
 - (4) Imposing other sanctions provided under the State plan.

[43 FR 45262, Sept. 29, 1978, as amended at 48 FR 3756, Jan. 27, 1983]

§ 455.17 Reporting requirements.

The agency must report the following fraud or abuse information to the appropriate Department officials at intervals prescribed in instructions.

- (a) The number of complaints of fraud and abuse made to the agency that warrant preliminary investigation.
- (b) For each case of suspected provider fraud and abuse that warrants a full investigation—
 - (1) The provider's name and number;
 - (2) The source of the complaint;
 - (3) The type of provider;
 - (4) The nature of the complaint;