State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
*DIRECTOR*

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**DATE:** June 24, 2022

**TO:** ALL MEDI-CAL DENTAL MANAGED CARE PLANS

**SUBJECT:** APL 22-005 Fraud, Waste, and Abuse Reporting

**PURPOSE:**
The purpose of this All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to clarify the process for the Medi-Cal Dental Managed Care (DMC) Plans to submit Fraud, Waste, and/or Abuse incidents to DHCS.

**BACKGROUND:**
Pursuant to Title 42 of the Code of Federal Regulations (CFR), section 438.608(a)(7), DHCS is required to specify in its contracts the Department's policy for DMC Plans to provide a prompt referral of any potential fraud, waste, and/or abuse they may identify to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit. Exhibit E (Additional Provisions), Provision 28, b, 2 of the DMC contract further requires DMC Plans to submit suspected fraud, waste, and/or abuse to DHCS within ten (10) business days of the date the DMC Plan first becomes aware of the activity.

This APL serves to provide additional guidance to DMC Plans on referring suspected fraud, waste, and/or abuse to DHCS.

**DEFINITIONS:**
Please note the following applicable definitions in connection with this reporting requirement:

**Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.[1]

[1] 4c CFR § 455.2; Welfare & Institution Code (WIC) § 14043.1(i)

**Waste** is the overutilization, underutilization or misuse of resources, and typically is not a criminal or intentional act.[2]

**Abuse** means provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for dental services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. [23]

**POLICY:**
DMC Plans must report to DHCS all cases of suspected fraud, waste, and/or abuse when there is reason to believe that an incident of fraud, waste, and/or abuse has occurred by subcontractors, members, providers, or employees. DMC Plans must conduct, complete, and promptly report to DHCS the results of a preliminary investigation of the suspected fraud, waste, and/or abuse within ten (10) business days of the date the DMC Plan first becomes aware of, or is on notice of, such activity.

Fraud, waste, and/or abuse reports must be submitted to DHCS' Audits and Investigations (A&I) Intake Unit and, at a minimum, include:

1. The number of complaints of fraud and abuse submitted that warranted preliminary investigation;
2. For each complaint which warranted a preliminary investigation, provide:
    a. Name and/or Social Security Number (SSN) or Client Index Number (CIN);
    b. Source of complaint;
    c. Type of provider (if applicable);
    d. Nature of complaint;
    e. Approximate dollars involved; and
    f. Legal and administrative disposition of the case.

The report must be submitted on the enclosed Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

1. Email at: PIU.Cases@dhcs.ca.gov;
2. E-fax at (916) 440-5287; or
3. U.S. Mail at:

    Department of Health Care Services
    Audits & Investigations Division
    Medi-Cal Fraud Intake Unit, MS 2500
    P.O Box 997413
    Sacramento, CA 95899-7413

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[2] Fraud, Waste, and Abuse Toolkit. Healthcare Fraud and Program Integrity: An Overview for Providers. (2015). Centers for Medicare and Medicaid Services. Retrieved at https://dbhids.org/wp-content/uploads/2015/10/Health-Care-Fraud-and-Program-Integrity-An-Overview-for-Providers.pdf.
[3] 42 CFR § 455.2 and as further defined in WIC §14043.1(a)

Furthermore, DMC Plans must submit the following components with the report or explain why the components are not submitted:

1. Police Report;
2. Health Plan's documentation, such as background information, investigation report, interviews, and any additional investigative information;
3. Member information, such as patient history chart, patient profile, claims detail report;
4. Provider enrollment data;
5. Confirmation of services;
6. List items or services furnished by the provider;
7. Pharmaceutical data from manufacturers, wholesalers, and retailers; and
8. Any other pertinent information.[4]

DHCS will follow-up with the DMC Plan throughout the duration of the investigation for status updates. DMC Plans are required to provide A&I the results, outcomes, and resolutions of the investigation within ten (10) business days after completing the investigation.

If you have any questions regarding this APL, please send them to: dmcdeliverables@dhcs.ca.gov.

Sincerely,

*Original signed by:*

Carolyn Brookins
Assistant Chief
Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure

[4] Exhibit E, Provision 28(b)(2) of DMC Contract