

ACCOUNTABLE BEHAVIORAL HEALTH ALLIANCE

Policy No. 043 Fraud and Abuse

Original Policy Date:	September 6, 2007
Next Review Date:	December 11, 2010
Revision History (approval):	September 6, 2007 December 11, 2009
Cross References:	<p>ABHA Policy # 003: Member Grievance, Appeal, and Hearing Process</p> <p>ABHA Policy # 004: Credentialing of Providers</p> <p>ABHA Policy # 15: Claims¹ Processing, Payment, and Oversight</p> <p>Oregon Regulations:</p> <p>ABHA Policy # 21: Third Party Resources</p> <p>ABHA Policy #040: Encounter Data</p> <p>Oregon laws include the following: ORS 411.670 to 411.690 (submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery); ORS 646.505 to 646.656 (unlawful trade practices); ORS chapter 162 (crimes related to perjury, false swearing and unsworn falsification); ORS chapter 164 (crimes related to theft); ORS chapter 165 (crimes involving fraud or deception), including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments); ORS 166.715 to 166.735 (racketeering – civil or criminal); ORS 659A.200 to 659A.224 (whistle blowing); ORS 659A.230 to 659A.233 (whistle blowing); OAR 410-120-1395 to 410-120-1510 (program integrity, sanctions, fraud and abuse); and common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses).</p>

Purpose:	To establish a procedure for detecting and reporting fraud and/or abuse
Policy:	ABHA’s intent is to fully comply with Federal and State fraud and abuse prevention and detection regulations. This Fraud and Abuse policy applies to ABHA and all its subcontractors:
Objective:	To monitor for potential fraud and abuse. To establish appropriate processes for fraud and/or abuse reporting.

¹ Includes both claims that are paid and claims that are encountered

<p>Scope:</p>	<p>This policy is applicable to all ABHA lines of business. It applies to both ABHA and its partner counties and, where applicable, its contracted providers. Each ABHA partner county serving ABHA members will develop, implement, and monitor a policy that is consistent with this ABHA policy.</p> <p>The Federal Deficit Reduction Act of 2005, Section 6032, requires that organizations receiving payments of at least five million dollars under a state Medicaid plan inform their employees about false claims recovery as described in the Federal False Claims Act (Title 31, United States Code) and Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs.</p> <ul style="list-style-type: none"> ○ <i>Should a county that receives less than \$5M in state Medicaid funding choose to develop its own Fraud and Abuse Policy, the ABHA policy will serve as the county's for ABHA members.</i>
<p>Procedure:</p>	<p>False Claims Act</p> <p>ABHA adheres to and requires through contract that contractors adhere to and comply with all provisions of the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b).</p> <p>ABHA will conduct annual trainings for staff that will include information about:</p> <ul style="list-style-type: none"> • Whistle blowing and related employee rights • Fraudulent activities • Contractor responsibilities <p>Information regarding these topics will also be provided in ABHA's Employee handbook</p> <p>ABHA will annually complete data analysis of claims paid data to determine whether there is evidence of abnormal billing practices or concerning payment patterns. ABHA has established internal fiscal management procedures that reduce the likelihood of administrative fraud or abuse.</p> <p>Prevention/Detection of Fraud and Abuse</p> <p>ABHA has in place internal controls, policies or procedures capable of preventing and detecting fraud and abuse activities as they relate to the Oregon Health Plan. This includes operational policies and controls in areas such as claims payment, prior authorization, utilization management and quality review, member complaint and grievance resolution, provider credentialing and contracting, provider and staff education. Corrective action plans will be developed, as needed. ABHA shall review its fraud and abuse policies annually.</p>

<p>Procedure:</p>	<p>ABHA has established the following administrative procedures to guard against fraud and abuse.</p> <ul style="list-style-type: none">• ABHA conducts annual staff trainings on this policy.• ABHA credentials and recredentials all contracted practitioners.• ABHA contracts only with agencies and facilities who are certified and monitored by the State of Oregon• ABHA has a quality assurance and review process and an established processes for filing complaints and grievances.• ABHA conducts audits of contracted providers, reviewing a random sample of treatment records. This includes a review of claims paid data.• ABHA monitors agency billing patterns to identify anomalies that might indicate fraud or abuse.• ABHA reviews individual authorizations and claims paid data to monitor for any potential fraud or abuse offenses.• These processes are designed to assure that all services billed for services to ABHA members were provided:<ul style="list-style-type: none">○ On the date billed○ For the length of time billed○ To the OHP member who received the services○ By an individual who is qualified to provide the service○ Representing a service that is consistent with and fully supported by the clinical record, is covered by the Oregon Health Plan, and coded accurately <p>Participation of Suspended or Terminated Providers</p> <p>The following persons (or their affiliates as defined in the Federal Requisition Regulations) may not provide the Covered Services provided by ABHA pursuant to Service Agreement:</p> <ul style="list-style-type: none">• Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issues pursuant to Executive Order No. 12549 or under guidelines implementing such order.• Persons who are currently suspended or terminated from the Oregon Medical Assistance Program. <p>ABHA shall not refer OHP members to such persons and shall not accept billings for services to OHP members by such persons.</p> <p>ABHA or its sub-contractors may not knowingly:</p> <ul style="list-style-type: none">• Have a person described above as a director, officer, partner, or person with beneficial ownership of more than five percent of the contractor's equity, or• Have an employment, consulting, or other agreement with a person described above for the provision of items and services that are significant and material to ABHA's obligations under Service Agreement.
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<p>Procedure:</p>	<p>Referral Policy ABHA is required to promptly refer all verified cases of fraud and abuse, including fraud by employees and sub-contractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between DHS and the MFCU. ABHA may also refer cases of suspected fraud and abuse to the MFCU prior to verification.</p> <p>Accountability: The ABHA Compliance Officer is responsible for providing staff with an annual education program on prevention and detection of fraud and abuse. He/she also serves as the organization’s Primary Contact for detecting, preventing, and reporting fraud and abuse. The Primary Contact is the designated individual employed by ABHA who ABHA:</p> <ul style="list-style-type: none">• Has selected as the first point of contact for the MFCU on any fraud or abuse complaints lodged with the state; and• Reviews and/or coordinates the response of ABHA to such fraud and abuse complaints. <p>ABHA’s Compliance Officer is accountable to the ABHA Audit Committee, which reports to the ABHA Governing Board, which is ultimately responsible for monitoring ABHA’s efforts to detect and prevent fraud and abuse.</p> <p>Fraud and Abuse Referral Characteristics of a Case that should be referred ABHA will promptly refer all verified cases of fraud and abuse, including fraud by employees and subcontractors of the organization to the Medicaid Fraud Control Unit (MFCU), consistent with the Memorandum of Understanding between DHS and the MFCU. Contractor may also refer cases of suspected fraud and abuse to the MFCU prior to verification.</p> <p>Should ABHA be aware that MFCU or DHS Fraud Unit are conducting an investigation, ABHA will not notify or otherwise advise any subcontractor or provider of the investigation, so as not to compromise the investigation.</p> <p>Examples of fraud and abuse that ABHA will refer to the MFCU:</p> <ul style="list-style-type: none">• Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records.• Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the clinical records.• Any verified case where the provider intentionally or recklessly billed ABHA more than the usual charge to non-Medicaid recipients or other insurance programs.• Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating and/or collecting Medicaid payments otherwise not due.
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<p>Procedure:</p>	<ul style="list-style-type: none">• Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP members.• Providers who intentionally fail to render medically appropriate covered services that they are obligated to provide OHP recipients under their contracts with the Prepaid Health Plan and under OHP regulations.• Providers who knowingly charge OHP members for services that are covered by OHP or who intentionally bill an OHP member the difference between the total fee-for-service charge and ABHA's payment to the provider, in violation of DHS rules.• Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.• Evidence of corruption in the enrollment process, including efforts of state employees to skew the risk of unhealthy patients toward or away from one of the Prepaid Health Plans.• Attempts by any individual, including employees and elected officials of the State, to solicit kickbacks or bribes <p>When to Report Fraud and Abuse An incident with any of the referral characteristics, as noted above, should be referred to the MFCU. Any other incident found to have characteristics which indicate fraud or abuse which ABHA has verified should also be referred. ABHA may also refer cases of suspected fraud and abuse to the MFCU or to DHS prior to verification.</p> <p>ABHA shall comply with all patient abuse reporting requirements and fully cooperate with the state for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable administrative rules. ABHA shall ensure that all subcontractors comply with this provision.</p> <p>How ABHA Staff Report Suspected Internal Fraud And Abuse ABHA staff will take any concerns regarding possible Fraud and Abuse violations to the ABHA Compliance officer. In the event that the person suspected is the ABHA Compliance Officer, staff will take their concerns to the ABHA Executive Director. In either case, all concerns will be taken to the Audit Committee and/or MFCU, as described in this policy.</p> <p>How to Refer a Case of Fraud or Abuse The MFCU: 1515 SW 5th Ave., Suit 410, Portland, OR 97201. Phone: 971-673-1880, fax number: 971-673-1890</p> <p>DHS Fraud Investigation Unit: P.O. Box 14150, Salem, OR 97309-5027 Phone number: (503) 378-6826, fax number: 373-1525.</p> <p>To report a verified or suspected incident of fraud or abuse, ABHA shall use the appropriate form to provide the information included therein:</p>
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<p>Procedure:</p>	<p>Obligations to Assist the MFCU or DHS</p> <ul style="list-style-type: none"> • ABHA shall promptly report all fraud and abuse as required under this section. • ABHA shall permit the MFCU or DHS to inspect, evaluate, or audit relevant books, records, documents, files, accounts, and facilities maintained by or on behalf of ABHA or by or on behalf of any subcontractors, as required to investigate an incident of fraud and abuse. • ABHA shall cooperate with the MFCU or DHS investigator during his or her investigation of fraud or abuse. • In the event that ABHA reports suspected fraud or learns of a MFCU or DHS investigation, it should not notify or otherwise advise its subcontractors of the investigation. Doing so may compromise the investigation. • Notification shall include: <ul style="list-style-type: none"> ➤ Provider Name ➤ Oregon Medicaid Number ➤ Address ➤ Type of Provider ➤ Source of complaint ➤ The approximate dollar amount involved ➤ The disposition of the complaint when known ➤ Number of complaints for the period <p>Obligations of Subcontracted providers to report to ABHA</p> <ul style="list-style-type: none"> • Subcontracted providers shall promptly report all suspected and documented fraud and abuse they identify within their program or within the system of care as required under this section. • Subcontracted providers shall permit ABHA, the MFCU or DHS to inspect, evaluate, or audit relevant books, records, documents, files, accounts, and facilities maintained by or on behalf of ABHA or by or on behalf of any subcontractors, as required to investigate an incident of fraud and abuse. • Subcontracted providers shall cooperate with ABHA, the MFCU or DHS investigator during his or her investigation of fraud or abuse. • <u>ABHA is obligated assist the MFCU and DHS without compromising their investigation.</u> • <u>ABHA will notify Mental Health Directors when ABHA learns of suspected fraud and abuse either when an investigation by the MFCU and/or DHS is complete or ABHA has determined through its own investigation that suspected fraud and abuse was not substantiated.</u> <p>Prevention and Detection of Member Fraud and Abuse OHP, if made aware of fraud or abuse by a member, (i.e. a provider reporting member fraud and abuse) shall report the incident to the MFCU.</p>
<p>Enforcement:</p>	<p>In addition to the responsibility to report suspected Fraud and Abuse to the MFCU, the ABHA Audit Committee will meet annually to review ABHA implementation of this policy and reports from the ABHA Compliance Officer.</p> <p>ABHA has developed the following set of disciplinary guidelines to follow when ABHA funds paid for services that were later determined to be fraudulent or Medicaid</p>

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	<p>abuse. They will be applied as recommended by the ABHA Audit Committee based on the severity of the concern. <u>Counties may need to vary personnel actions described below, in order to be consistent with their own personnel policies and union contracts.</u></p> <ul style="list-style-type: none">• <u>If Medicaid abuse is determined ABHA may require restitution. If Medicaid fraud is determined ABHA will require restitution of funds paid.</u>• <u>If a non-intentional problem is identified, a corrective action plan will be developed and ABHA will monitor compliance.</u>• <u>If intentional fraud or abuse offenses are detected, they will be immediately reported to the Office of Payment Accuracy and Recovery.</u>• <u>ABHA may implement any of the following in response to intentional fraud or abuse:</u><ul style="list-style-type: none">○ <u>Put a credentialed employee on probationary status and terminate provider approval until the issue is resolved.</u>○ <u>Put a contracted provider on probationary status and terminate billing authority until the issue is resolved.</u>○ <u>Remove a credentialed employee from ABHA provider panel</u>○ <u>Terminate a contract with a ABHA provider.</u>
Forms:	ABHA Contractor Quarterly Report ABHA QMHA/P Application Addendum A: Credentialing Disclosure Assessment ABHA QMHA/P Application Addendum B: Credentialing Disclosure Certification

December 11, 2009
Date approved by the Governing Board

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DEFINITIONS

ABUSE (of member) means intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault.

ABUSE (by ABHA or provider) means ABHA or provider practices that are inconsistent with sound fiscal, business, administrative or medical practices and result in pattern of demonstrable increased costs to the Oregon Health Plan (OHP) program.

ABUSE (by member) means recipient practices that result in unnecessary costs to the OHP program.

FRAUD (by OHP member, ABHA, provider, or State employee) means an intentional, knowing or reckless practice that results or could result in the receipt of an unauthorized benefit by the person or entity engaged in the conduct, or the deprivation of goods and services to a member who is entitled to those goods and services under the OHP program. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2) OHP member fraud may include a member's misuse of a ABHA-issued membership card or DHS-issued identification, altering or forging of a prescription, theft or any fraudulent activity committed against ABHA or any subcontractor of ABHA.

MEDICAID FRAUD CONTROL UNIT (MFCU) is a federally mandated unit operating within the Office of the Attorney General which investigates provider fraud and abuse in the Medicaid (including the OHP) program, fraud in the administration of the program, and patient abuse in Medicaid-funded facilities.