AMERIHEALTH CARITAS FAMILY OF COMPANIES

POLICY AND PROCEDURE

Supersedes: N/A

Policy No: 106.100
Page: 1 of 6

Subject: Corporate and Financial Investigations: Overview of Responsibilities

Department: Payment Integrity

Current Effective Date: 7/18/13
Last Review Date: 10/2/12
Original Effective Date: 11/4/08
Next Review Date: 7/18/14

Unit: Corporate and Financial Investigations

Stakeholder(s): Compliance

Review Cycle: Annual

Applicable Party(s): All AmeriHealth Caritas associates, contractors, and consultants

Line(s) of Business: AmeriHealth Caritas Health Plan, AmeriHealth District of Columbia, Arbor Health Plan, Florida True Health, Keystone First Health Plan, LaCare, MDwise Hoosier Alliance, PerformCare (Community Behavioral HealthCare Network of PA), PerforMED, PerformRx, Select Health of South Carolina, Keystone VIP Choice, AmeriHealth VIP Care, and Select Health VIP Care

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Policy: The Corporate and Financial Investigations (CFI) unit is charged with preventing, detecting, investigating, and reporting fraud, waste, and abuse (FWA) for the AmeriHealth Caritas Family of Companies (referred to as the "Company"). CFI accomplishes this by:

a) Preventing fraud and abuse by identifying vulnerabilities in the Company's program (s) and recommending or taking remedial action.
b) Proactively detecting potential incidents of fraud and abuse by applying edits during, and immediately following, claims adjudication, and using information maintained in the Company data warehouse system for retrospective data mining.
c) Determining the factual basis of allegations concerning fraud or abuse made by members, providers and others.
d) Initiating appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud or abuse.
e) Referring fraud and abuse cases to the appropriate parties for investigation for possible civil and criminal prosecution and administrative sanctions.
f) Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with internal components of the Company as well as outside groups.
g) Reporting suspected or confirmed instances of fraud or abuse to state Medicaid agencies and/or CMS as applicable and required by each oversight agency..
h) Making recommendations to enhance the Company's ability to detect, correct, prevent, and report fraud and abuse.
i) Identifying and/or providing information for potential class action law suits.
j) Working with vendors to identify and prevent FWA.

Purpose: To inform and educate associates of CFI's responsibilities to prevent, detect, investigate, and report fraud and abuse, as well as the importance of referring suspected Fraud, Waste, and Abuse to the CFI unit.

Definitions:

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare or Medicaid Programs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Company is the AmeriHealth Caritas Family of Companies.

EXP™ Service Form: The EXP electronic form used to document the member or provider calls which can be routed to assisting departments/individuals for call resolution.

EXP™ System: Electronic HealthCare call documentation and inquiry routing system used to document and route all inquiry data, phone interaction notes, and case related email (electronic correspondence within and between the companies and department) communication.

Fraud means deliberate actions which result in illegally obtaining payment or something of value for services, or illegally obtaining medical services. It may be an intentional deception, misrepresentation, or concealment of material facts by a provider or recipient with the knowledge that the deception could result in some unauthorized benefit, gain, or unjust advantage to him or herself or some other person.

Examples of provider fraud include purposely billing for services that were never given or billing for a service that has a higher reimbursement than the service provided. Examples of member fraud include pharmacy/doctor shopping, card sharing, and abuse of services.

HIPAA Definitions: See Policy # 168.235 HIPAA Definitions

Waste means thoughtless, careless or otherwise improper use of services by members, provision of and billing for such services by providers, or payment for the services by payors. Waste includes erroneous claims adjudication by the Company.

Waste, as defined by CMS for Medicare Part D, means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

A. Fraud, Waste, and Abuse Complaints

A CFI audit/investigation begins upon receipt of information that suggests claims are being paid inappropriately. The sources can be referrals, retrospective data mining or prospective deny/pend trending. Referrals are received from a variety of internal and external sources.

1) Internal Sources may include:

a) Company Associates. These associates generally report their suspicions to their supervisor. The supervisor evaluates the activities and determines if any additional action is required. If the information received is indicative of fraud, waste, or abuse, the supervisor shall either refer or direct the associate to refer the information to CFI for investigation/audit.

b) Internal reports which may include, but are not limited to, data warehouse queries, internal/external audits, trend reports received from various departments, and evaluation of prospective denied and pended claims.
c) Internal Hotline calls, EXP™ service form referrals, and emails.

2) External Sources may include:

a) Written/verbal complaints received from members and/or providers regarding suspicious treatments and/or billing
b) Letters received through the United States Postal Service or a similar mail service (e.g., FedEx, UPS)
c) Telephone complaints received on the FWA hotline
d) Media Reports
e) Fraud alerts issued by other health insurance providers
f) Information released by the U.S. Department of Health and Human Services, Office of the Inspector General, CMS or Medicare Drug Integrity Contractors (MEDICs)
g) Information received from licensing boards, Medicaid or Medicare agencies
h) Information received from additional sources such as insurance carriers, colleagues, former associates, spouses, outreach phone calls made to members to verify services rendered, etc.
i) External vendors providing FWA services on our behalf

3) Examples of FWA issues that may be reported include, but are not limited to, the following:

a) Billing for services not provided
b) Falsifying medical diagnoses or procedures to maximize payments
c) Misrepresentation of dates
d) Invalid descriptions of services or identities of subscribers/providers
e) Billing for a more costly service than the one that was provided or billing for duplicate services
f) Accepting bribes for patient referrals
g) Billing for non-covered items (e.g. cosmetic surgery)
h) Credit balances with failure to refund overpayment
i) Providing false membership information
j) Prescription fraud

B. Fraud Data Mining

1) The CFI and vendors acting on our behalf, use various data/reporting sources to identify patterns of fraud, waste, and/or abuse. Such patterns are identified both proactively through data mining/trend identification and reactively (e.g., in response to receiving Tips) and include:

a) Over utilization
b) Up-coding
c) High dollar claims
d) Unusual patterns by members, providers, or facilities
e) Unusual dates of service
f) Excessive time units for time based codes
g) Unusual claims volume by providers or members
h) Unbundling services
i) Incorrect reimbursement to providers, members, facilities and /or pharmacies
j) Incongruous procedure code, prescription and diagnostic code combinations

C. CFI Training, Compliance, and Liaison Activities

1) Training

a) The CFI unit facilitates a structured FWA education and training program for corporate associates. This training is offered to new associates in the corporate new hire orientation program and others as required by law. The following points are addressed:

i) CFI's mission and purpose
ii) Identification of suspicious fraud, waste, and/or abuse scenarios
iii) CFI referral process

2) Compliance

a) Annually, as a condition of continued employment, every associate (includes full time, part time and temporary, contractors, and consultants) must read, and indicate by signature, their understanding of the Company Code of Conduct. The Code of Conduct instructs associates to report suspected FWA to the CFI unit.

b) CFI refers violations of laws and/or regulations to the appropriate regulatory and/or law enforcement agencies. CFI associates who are aware of any suspected violations of the Code of Conduct and fail to report it to the CFI Management and/or the Corporate Compliance Officer are subject to disciplinary action up to and including termination of employment. In addition, they may be referred to the appropriate regulatory and/or law enforcement agencies.

3) Liaison Activities External

a) During the course of an audit/investigation, CFI staff members may communicate with federal, state, and local law/regulatory enforcement agencies. The following external entities represent those with whom CFI most commonly collaborates in an investigation of healthcare FWA.

b) <u>Federal</u>
i) U.S. Attorneys
ii) U.S. Postal Service
iii) Federal Bureau of Investigations
iv) Federal Drug Enforcement Administration
v) Internal Revenue Service
vi) Department of Defense Criminal Investigative Service
vii) Department of Health & Human Service – Office of the Inspector General
viii) CMS Medicare Drug Integrity Contractors (MEDICs).

c) <u>State</u>
i) Medicaid Agency Program Integrity Unit
ii) Insurance Departments
iii) Attorney General/ Medicaid Fraud Control Unit
iv) Police
v) Fraud Bureau
vi) Local District Attorney's Office
vii) Investigating bodies

d) <u>Other</u>
i) Local Police Departments
ii) National Health Care Anti-Fraud Association
iii) National Association of Insurance Commissioners
iv) Association of Certified Fraud Examiners

e) **Liaison Activities Internal**
i) During the course of an audit/investigation, CFI staff members may communicate with various internal departments. The following departments are not an all-inclusive list of internal liaisons, but instead, represent the most common:
(a) Corporate Compliance
(b) Medical Directors
(c) Medical consultants acting on the behalf of the Company
(d) Quality Management
(e) Provider Network Management

(f) Legal Department
(g) Human Resources

D. CFI Associates' Roles

1) **Research and Reporting Analysts** develop, complete, and generate internal and external standard and ad hoc reports, assisting with interpretation and trend identification; draft periodic and ad-hoc reports; act as CFI liaison with assigned health plan; triage and set up incoming referrals in the CFI case tracking system

2) **Clinical Review Nurses** are familiar with billing practices, coding, medical terminology and medical record charting. Using their Certified Professional Coder (CPC) coding background, they review professional provider billings to determine the presence of unsupported charges. They also identify under-utilization and over-utilization of medical services, billing inaccuracies, unbundling of charges, inappropriate Current Procedural Terminology (CPT) coding and processing errors leading to overpayments.

3) **Investigators** review referrals, gather information related to allegations, evaluate findings to determine if evidence indicates billing errors, over utilization, abusive activity, or a strong suspicion of fraud or abuse. Additionally, they work closely with analysts to mine claims data for potential overpayment identification and case development.

4) **CFI Management** will determine, in conjunction with others as required, the appropriate course of action based upon an evaluation of the investigation's results to date. The course of action may include any of the following:
   a) Referral for Administrative Handling
   b) Continued Investigation/Preliminary Review of Facts with Law Enforcement
   c) Validation of claims submitted to services rendered by pending claims for medical record review.
   d) Request for Repayment
   e) Criminal Referral
   f) Civil Action

E. Related Policies and Procedures:

a. Corporate Code of Conduct, Policy #168.102
b. Referrals and Case Tracking, Policy # 106.500
c. Suspending Provider Claims, Policy #106.300
d. Associate Guidance on Reporting Fraud Waste or Abuse, Policy #106.600
e. Fraud and Abuse Investigations, Policy #106.1000
f. HIPAA Definitions, Policy # 168.235
g. General Policy – Use and Disclosure of Protected Health Information without Member Consent/Authorization, Policy # 168.227
h. Minimum Necessary Rule, Policy # 168.217
i. General Guidelines to Safeguard Protected Health Information, Policy # 168.213
j. Safeguards to Protect the Privacy of Protected Health Information, Policy # 168.222
k. Document Retention Period: Documents Relating to the Privacy of Protected Health Information, Policy # 168.237

Superseded Policies and Procedures:

Approved By:

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