PerformCARE®	Policy and Procedure
Name of Policy:	Reporting Suspected Provider Fraud, Waste and Abuse
Policy Number:	CC-001
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Payment Integrity
Related Stakeholder(s):	PerformCare Compliance, Claims, Credentialing Committee, Provider Relations
Applies to:	Associates
Original Effective Date:	10/01/01
Last Revision Date:	12/02/21
Last Review Date:	12/02/21
Next Review Date:	12/01/22

Policy: PerformCare seeks to ensure the integrity of the HealthChoices program by investigating any reported or alleged fraud, waste, or abuse by a network Provider. The Program Integrity Department Special Investigations Unit (SIU) is charged with preventing, detecting, investigating and reporting fraud, waste and abuse (FWA) for PerformCare. The SIU is responsible for the preventing, detecting, correcting, investigating, and reporting fraud, waste and abuse within the HealthChoices Behavioral Health program across the PerformCare provider network (e.g. provider fraud).

Purpose: To ensure that PerformCare is in compliance with Appendix F of the Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program, Program Standards and Requirements.

Definitions: **Abuse:** Any actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, 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 can 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.

Abuse is defined in §42 CFR Part 455.2 as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

Bureau of Program Integrity (BPI): The Commonwealth of Pennsylvania Office of Medical Assistance Programs Bureau that ensures Medical Assistance (MA) Program is protected from provider fraud, abuse and waste, and that MA recipients receive quality medical services.

Center for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.

Department of Human Services (DHS): The single state agency with responsibility of the implementation and administration of the Medial Assistance Program (Medicaid or MA).

Explanation of Benefits (EOB): A statement sent by a health insurance company to covered individual explaining what medical treatments and/or servicers were paid for on their behalf.

Fraud: Any deliberate action which results 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.

Fraud is defined in §42 CFR Part 455.2 as 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.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): An Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

Medicaid Fraud Control Unit (MFCU): The section or unit of the Office of the Attorney General responsible for the investigation and prosecution of Medicaid provider fraud as well as patient abuse or neglect in health care facilities and board and care facilities.

National Correct Coding Initiative (NCCI): A Center for Medicare & Medicaid Services program designed to prevent the improper payment of procedures that should not be submitted together.

Oversight Agencies: Department of Human Services, Bureau of Program Integrity; the Office of the Attorney General's Medicaid Fraud Control Section; the Pennsylvania State Inspector General; Center for Medicare and Medicaid Services Office of Inspector General, and the United States Justice Department.

PerformCare Compliance Director: PerformCare Compliance Director serves as the Compliance Officer for PerformCare and is responsible for internal and external fraud, waste, and abuse monitoring and training. The Director ensures systematically that contract obligations are monitored and met; serves as the

privacy officer to ensure corporate structure adheres to HIPAA; and spearheads the employee code of conduct implementation.
PerformCare Executive Director: The Executive Director is to be kept apprised of the SIU investigations and monitor sensitive cases to provide updates to the County Oversights and meet with Providers as necessary.
Special Investigation Unit (SIU): The AmeriHealth Caritas Family of Companies/PerformCare unit responsible for preventing, detecting, correcting, and reporting fraud, waste, and abuse across various categories of health care (e.g. provider fraud, Member fraud, or external fraud).
SIU Director: An employee position responsible for the management and overall direction of the unit to ensure its primary objectives – to prevent, detect, investigate, and correct fraud, waste, and abuse.
SIU Manager/Fraud Waste and Abuse (FWA) Coordinator: An employee position dedicated to preventing, detecting, investigating, and referring suspected Fraud, Waste and Abuse in the HealthChoices Behavioral Health program to Department of Human Services, responsible for generating and drafting internal and external standard and ad-hoc reports and the triage of incoming referrals.
Clinical Investigator: An employee position responsible for reviewing referrals, gathering information related to the allegations, conducting clinical reviews and claims audits and evaluation of findings to determine if evidence indicates billing errors, over-utilization, abusive activity, or a strong suspicion of fraud or abuse. Contributes to the interpretation and trend identification in documentation and claims submission for potential referrals to the SIU through assigned case investigation.
Intake Specialist: An employee position responsible for the receipt, development, completion, and entering of incoming referrals in the SIU case tracking system.
Third Party Liability (TPL): Any individual, entity (e.g., insurance company), or program (e.g., Medicare) that may be liable for all or part of a Member's health care expenses.
Waste: The 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 payers. 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.

Acronyms: None

Procedure:

1. PerformCare Identification of Fraud, Waste, or Abuse

1.1. All PerformCare associates are trained upon hire and annually to monitor and report suspected incidents of internal or external fraud, waste, and abuse.

1.1.1. The PerformCare staff identifying the suspected violation will notify their Supervisor or any member of PerformCare Executive

Management and report the potential fraud, waste or abuse, to the Special Investigations Unit (SIU) in one of the following ways:

a) Phone, call the Fraud Tip hotline at (866) 833-9718
b) Send email to FraudTip@amerihealthcaritas.com
c) Mail, Corporate and Financial Investigations, 200 Stevens Drive, Philadelphia, PA 19113
d) Submit a Fraud Tip Form which can be found on iNSIGHT
e) Fax at (215) 937-8731
f) Speak with a member of the PerformCare Special Investigations Unit
g) Reports can be made anonymously

1.1.2. If an allegation is externally reported by phone, the PerformCare associate receiving the report of fraud, waste, or abuse will:

a) Transfer the individual to the SIU Department; or
b) Forward a voice message to the SIU Department; or
c) Contact a member of the SIU Department and communicate all the information received from the external phone call.

2. General Procedures

2.1. The PerformCare FWA Coordinator or designee will report suspected fraud, waste and abuse within 30 business days of the date of discovery to the DHS Bureau of Program Integrity's Managed Care Unit.

2.2. Member fraud, waste and abuse

2.2.1. Includes behaviors defined within other protective services reporting requirements, e.g. physical/sexual/verbal abuse, to a PerformCare Member, or discrimination by a Provider against a HealthChoices Member.

2.2.2. The reporting of Member physical/sexual/verbal abuse by a Provider to the DHS BPI Managed Care Unit is the responsibility of the PerformCare Quality Improvement Department.

2.2.3. Any referrals received by the PerformCare SIU regarding Member fraud, waste or abuse, will be forwarded to the QI Department.

2.3. Provider fraud, waste and abuse

2.3.1. The FWA Coordinator or designee shall ensure that PerformCare complies with applicable federal regulatory requirements and DHS mandatory or statutory regulatory requirements with respect to FWA.

2.3.2. PerformCare will ensure County Oversight notification through a report of HealthChoices Contractor Provider investigations. This report is sent to each respective oversight entity on a monthly or quarterly basis in accordance with regional specifications.

2.3.3. PerformCare expects providers to periodically review their records for possible regulatory violations or overpayments and submit a referral of findings via the methods listed in 1.1.1.

a) As an incentive to Medical Assistance (MA) providers, DHS will accept reimbursement for inappropriate payments without penalty in the event that the inappropriate payments are disclosed voluntarily and in good faith.
b) The Office of Medical Assistance Programs (OMAP) provides a list of examples of inappropriate payment situations suitable for self-audits, and methods to conduct self-audits and return overpayments, at the OMAP web site at: http://dhs.pa.gov

3. SIU Investigation of Fraud, Waste, or Abuse

3.1. The SIU will review the incident to determine if there is an immediate safety concern.

3.1.1. If there is an immediate safety concern, the SIU will immediately notify the PerformCare Quality Improvement Department for further follow up.

3.1.2. If there is not an immediate safety concern, the incident shall be logged and subsequently tracked by the SIU using the case tracking online database.

3.2. Based on their assessment of the information, the SIU determines whether additional information is needed from the referral source and whether or not the case meets fraud, waste, or abuse criteria and requires further investigation. The reason for an audit will not be reported to the provider, as per the direction from MFCU. The following can be part of an SIU investigation which could lead to a referral or report to the BPI:

3.2.1. If the outcome of the record review shows evidence of potential fraud, waste, or abuse, such as an identified overpayment for the violation of established regulations, Medical Assistance Bulletins, PerformCare P&P/Provider Alerts, PerformCare Provider Handbook, etc., the incident will be reported to the BPI and the MFCU.

3.2.2. If during the review of complaints or reports from former or current employees of a provider or referral source allege knowledge of intentional misconduct with the purpose of obtaining payment for which the provider/individual is not entitled, the SIU will report the incident to the BPI and the MFCU.

3.2.3. If the SIU expands a routine audit, (i.e., those audits that were not triggered by a complaint or suspicion of improper conduct) and subsequent findings meet the FWA criteria, such as an identified overpayment as listed in 3.4.1, the SIU will report the findings to the BPI and the MFCU.

3.2.4. In cases of alleged billing/record keeping issues, suspected provider fraud, waste, or abuse and/or employee/subcontractor theft or embezzlement, the SIU will conduct the investigation

with oversight by the FWA Coordinator or designee. The findings will be referred to the BPI and the MFCU.

3.3. The SIU, after review by the FWA Coordinator or designee, will document all investigations and case actions on investigations in the SIU database and maintain records of all reports of providers. The investigation information will be shared only on a need- to-know basis with PerformCare as per direction from MFCU.

3.4. When the SIU conducts an external investigation, the process will be as follows:

3.4.1. The SIU will review the referral and contact the person making the allegation in order to obtain additional information, if needed.

3.4.2. The SIU will send a letter to the provider requesting medical records for the level of care under review, staff caseloads, and further information pertaining to a self-report by a provider or other provider documentation. The SIU will not contact the provider if all the information for the referral is provided from PerformCare or other referral sources to the SIU.

3.4.3. The SIU, including the FWA Coordinator or designee, will determine if it is necessary to send an audit team from the SIU to the provider site to further investigate the allegations of the referral and/or obtain medical records.

3.5. The SIU may request that the provider submit a self-report of their internal review of medical records and related documentation if the referral to the SIU indicates that the provider reported the allegation to a PerformCare associate.

3.6. The SIU, PerformCare, and the County Oversight should not disclose the allegation to the provider if intentional criminal conduct is suspected, as the case has the potential to be referred to the MFCU.

3.7. If potential fraud is suspected, the SIU will refer the case to the MFCU. If potential fraud, waste, or abuse is suspected, the SIU will refer the case to the BPI and the MFCU using the MCO Referral Form and instructions to submit referrals to BPI found on the HealthChoices website: https://www.humanservices.state.pa.us/hc-extranet/forms/form_mcoreferral_mc.asp

4. After investigations are completed

4.1. The SIU will prepare a Case Summary Report of all findings, including a recommendation to address the allegation.

4.2. The SIU member assigned will review the report with the FWA Coordinator, or designee, for approval prior to the report being finalized.

4.3. When the SIU has been able to substantiate an allegation as potential fraud, waste, or abuse, and the violation of established regulations, Medical Assistance Bulletins, PerformCare P&P, Provider Alerts, the provider Handbook, etc. is found to be a pervasive issue in multiple medical records or documentation reviewed or if the findings for the provider in prior cases of the same level of care have found the same

pervasive violations, the provider may be required to submit a Quality Improvement Plan (QIP).

4.3.1. The FWA Coordinator or designee and SIU member assigned will review and approve the QIP, assuring that it includes methods of monitoring progress, meets specified time lines for compliance, and permanently corrects any and all improper conduct.

4.3.2. The QIP will be based on applicable laws and regulations governing the report of fraud, waste, and abuse in Pennsylvania MA programs. QIPs are monitored by the PerformCare Quality Improvement Department, as per *QI-SIU-001 Development and Monitoring of Quality Improvement Plans Issued by the Special Investigations Unit*.

4.4. Notwithstanding any corrective action by other oversight agencies, PerformCare may also take disciplinary action against the provider that may include recoupment of improper payment, reporting of findings to the PerformCare Credentialing Committee; and/or suspension or termination from the provider network.

5. Cost Avoidance

5.1. The PerformCare Claims Department utilizes National Correct Coding Initiative (NCCI) edits, per CMS, within the claim processing system to prevent improper payment when incorrect code combinations are billed. Additional cost avoidance activities include denying Third Party Liability (TPL) claims billed when the primary insurance was not billed first and claims billed that are missing the Explanation of Benefits (EOB).

6. FWA Activities and Oversight Agencies

6.1. The SIU will send all provider self-disclosed criminal conviction to the MFCU and the BPI within thirty (30) days of discovery or notification.

6.2. The SIU will notify BPI of all providers suspected of leaving the network due to a fraud, waste, or abuse investigation via the BPI MCO quarterly report.

6.3. The PerformCare Quality Improvement/Credentialing Department, in accordance with Credentialing Policies and Procedures, will notify BPI and OMHSAS when they refuse to credential or re-credential a provider or primary contractor due to fraud, integrity, or quality.

6.4. The SIU may be contacted by the BPI if they determine the provider is already under review by the BPI or the MFCU. If the BPI or the MFCU review activities are in process, they may ask that the PerformCare SIU suspend or halt review activities, or coordinate activities with the relevant agency. The BPI is also available to offer direction or technical assistance in planning the review. The SIU will cooperate with all involved federal, state and county agencies pertaining to a particular investigation.

6.5. PerformCare will notify the BPI either directly or through the primary contractor when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid or Title XX when making application to be credentialed as a BH-MCO network provider or upon renewal of their credentialing. The Primary Contractor or its BH-MCO shall also notify the BPI of an associated adverse action, such as convictions, exclusions, revocations, and suspensions, taken on provider applications, including denial of initial enrollment due to fraud, integrity issues or quality.

6.6. Once the SIU reports a provider to an oversight agency for potential fraud, waste, or abuse, any complaint or grievance received from the provider must be directed to the applicable agency, per contractual obligations of the HealthChoices program.

7. Recipient Verification Process

7.1. Recipient Verification Process: Each quarter, as directed by the PerformCare Compliance Officer, claims are randomly selected to be verified through letters sent to MA recipients. The letters are sent at the beginning of each quarter and the recipients are directed to contact the SIU if they feel the services listed were billed in error. The recipient verifications completed each quarter are reported on the MCO Quarterly Report due to BPI by the 15th of the month after the quarter ends.

Related Policies:

CC-002 Fraud, Waste and Abuse Program
CC-003 Provider Audits Conducted by the Special Investigations Unit
CC-004 Reporting Suspected Recipient Fraud, Waste and Abuse
PR-003 Ongoing Monitoring of Quality, Sanctions & Complaints
QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers
QI-CR-005 Credentialing Committee
QI-SIU-001 Development and Monitoring of Quality Improvement Plans Issued by the Special Investigations Unit

Related Reports:

None

Source Documents and References:

Commonwealth of Pennsylvania Department of Human Services HealthChoices Behavioral Health Program, Program Standards and Requirements
Child Protective Services Law, 55 Pa. Code § 3490.11. Reporting suspected child abuse
Older Adults Protective Services Act, P.L.1125, No.169
MA Bulletin 99-11-05 Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs

Title 42 – Public Health §42 CFR Part 455.2

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 MCO Fraud, Waste and Abuse Reporting Requirements*
Attachment 2 BPI MCO Referral Form
Attachment 3 BPI MCO Referral Supporting Documentation Checklist

Approved by:

Leslie Marshall
Primary Stakeholder

PerformCARE®

CC-001 Attachment 1

MCO FRAUD, WASTE AND ABUSE REPORTING REQUIREMENTS

1. Examples of Suspected Fraud, Waste and Abuse: The following are examples of suspected fraud, waste and abuse that must be reported. Contractor may reference Chapter 55 Pa. Code Section 1101 et seq. and the specific regulations relating to each provider type for further guidance.

Billing / Record Keeping Issues
Falsifying/altering claims/ encounters/records
Up coding / Incorrect coding
Double billing / Unbundling
Duplicate billing for the same service or a different service concurrently to the same Member
Providing unnecessary services/over utilization
Providing substandard or inappropriate care
Billing for services/ supplies not rendered
Billing for more time or units of services/ supplies than provided
Failing to maintain appropriate records
Any issue that could result in collection of overpayment

Suspected Member Fraud / Abuse
Prescription alteration or forgery
Inappropriate use of member's card
Duplication of medications/services
Frequent ER visits; physician, pharmacy, or hospital "shopping"

Abuse of a Member
Physical, mental, sexual
Discrimination

Employee / Subcontractor Theft or Embezzlement

2. Reporting Suspected Provider Fraud, Waste, and Abuse: The Contractor's fraud, waste and abuse unit must report suspected provider fraud, waste, and abuse within 30 business days.

Submit "MCO Reporting Form" through the secure internet site
https://www.humanservices.state.pa.us/hc-extranet/forms/form_mcoreferral_mc.asp

Or mail to:
Department of Human Services (DHS)
Office of Administration
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, PA 17105-2675

3. Reporting Suspected Member Fraud and Abuse:
Report to:
DHS Bureau of Program Integrity
Recipient Restriction Program
PO Box 2675
Harrisburg, PA 17105-2675

1-866-397-8477 (office)
717-772-4655 (fax)

Pennsylvania HealthChoices
Extranet

Bureau of Program Integrity
MCO Referral Form

Please review the form instructions prior to each use as they may have changed. Form Instructions

***MCO :** Select From List

MCO Tracking Number :

Date of Referral : 11/24/2021

***Referral Type :** Select From List

***Participant Type :** Select From List
Potential Recipient Restrictions are not to be reported on this form.

***Participant Name :**

National Provider Identifier (NPI) Number : Format: 9999999999

Provider ID Number : - Format: 999999999 - 9999
(MPI - Service Location)

***Service Location Address :**

***City, St, Zip :** , , -

***Does this involve a MA recipient?** Yes No

***County Where Incident Occurred :** Select From List

***Provider Phone Number :** Format: 888-888-8888

***Provider License Number :**

DEA Number :

***Provider Type :** Select From List

***Provider Specialty :**

***Date(s) of Service/Date(s) of Incident :**

From Date : Format: MM/DD/YYYY

To Date : Format: MM/DD/YYYY

***Method by which the MCO became aware of this issue :**
(Ex: Hotline, Data Mining, etc)

***Potential Witness/Contact Information (Names, Titles, Addresses, Phone Numbers) :**

***Estimated Amount of Money Involved :** $ Format: 0.00

***Did the MCO recover any amount? :** Yes No

***Describe the issue under review, citing the procedure/diagnosis codes and descriptions, violation(s) of Regulations, etc. :**

Check all appropriate boxes below and give detailed answers to the corresponding questions.

***Were claims reviewed?** Yes No

Date(s)/Date Range Reviewed:

Number Reviewed:

Describe in as much detail as possible what findings resulted from the claims review:

***Were medical records reviewed?** ○ Yes ○ No

Date Range Reviewed:

Number Reviewed:

***Are medical records being submitted to BPI?** ○ Yes ○ No

***Was the provider interviewed?** ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

***Were the provider's staff interviewed?** ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

***Were recipients interviewed?** ○ Yes ○ No

Describe in as much detail as possible the findings from the interview(s):

***Is there any other relevant Information or case outcome?** ○ Yes ○ No

Describe and indicate findings:

☐ *** In accordance with the HealthChoices Agreement, all supporting documentation as required on the Checklist of Supporting Documentation for Referrals, including relevant claims, medical records, and other supporting documentation has been downloaded to the appropriate MCO folder on DocuShare. All incomplete referrals will be rejected and considered in breach/violation of the requirements listed in the HealthChoices Agreement and noted on the MCO Quarterly Compliance Report.**

***Submitted By :**

** Required Fields*

Submit Clear Form

PerformCARE®

CC-001 Attachment 3

MCO _____
MCO Tracking #_____
Date Referred_____

Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for provider or staff person referrals-

- ☐ Confirmation page from online referral
- ☐ Encounter forms (lacking signatures or forged signatures)
- ☐ Timesheets
- ☐ Attendance records of recipient
- ☐ Written statement from parent, provider, school officials or client that services were not rendered or a forged signature
- ☐ Progress notes
- ☐ Internal audit report
- ☐ Interview findings
- ☐ Sign-in log sheet
- ☐ Complete medical records
- ☐ Resume and supporting resume documentation (college transcripts, copy of degree)
- ☐ Credentialing file (DEA license, CME, medical license, board certification)
- ☐ Copies of complaints filed by members
- ☐ Admission of guilty statement
- ☐ Other:_____

Example of materials for pharmacy referrals-

- ☐ Paid claims
- ☐ Prescriptions
- ☐ Signature logs
- ☐ Encounter forms
- ☐ Purchase invoices
- ☐ EOB's
- ☐ Delivery slips
- ☐ Licensing information
- ☐ Other: _____

Example of materials for RTF referrals-

- ☐ Complete medical records
- ☐ Discharge summary
- ☐ Progress notes from providers, nurses, and other staff
- ☐ Psychological evaluation
- ☐ Other: _____

Example of materials for behavioral health referrals-

- ☐ Complete medical and mental health record
- ☐ Results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ Summaries of all hospitalizations
- ☐ All psychiatric examinations
- ☐ All psychological evaluations
- ☐ Treatment plans
- ☐ All prior authorizations request packets and the resultant prior authorization number
- ☐ Encounter forms (lacking signatures or forged signatures)
- ☐ Plan of care summaries
- ☐ Documentation of treatment team or Interagency Service Planning Team meetings
- ☐ Progress notes
- ☐ Other: _____

Example of materials for DME referrals-

- ☐ Orders, prescriptions, and/or certificates of medical necessity (CMN0 for the equipment
- ☐ Delivery slips and/or proof of delivery of equipment
- ☐ Copies of checks or proof of copay payment by recipient
- ☐ Diagnostic testing in the records
- ☐ Copy of company's current licensure
- ☐ Copy of the Policy and Procedure manual applicable to MDE items
- ☐ Other: _____