PerformCARE®	Policy and Procedure
Name of Policy:	Fraud, Waste, and Abuse Program
Policy Number:	CC-002
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Payment Integrity
Related Stakeholder(s):	PerformCare Compliance
Applies to:	All PerformCare Associates, Contractors, Consultants, Subcontractors, Vendors and Delegates
Original Effective Date:	07/01/05
Last Revision Date:	06/25/21
Last Review Date:	06/30/21
Next Review Date:	06/01/22

Policy: PerformCare shall establish and maintain a Fraud, Waste, and Abuse Program consistent with the Fraud, Waste, and Abuse Program Requirements as presented in Appendix F of the Commonwealth of Pennsylvania Department of Human Services (DHS) HealthChoices Behavioral Health Program, Program Standards and Requirements.

Purpose: To ensure that PerformCare is in compliance with 42 CFR 438.608 Program Integrity Requirements and Appendix F of the HealthChoices Behavioral Health Program Standards and Requirements (PSR). The Special Investigations Unit (SIU) for PerformCare 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).

Definitions: **Abuse:** Per CMS definition of Fraud and Abuse – Regulatory Citation 42 CFR 455.2 "abuse" is provider practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medical Assistance Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
Compliance Committee: A committee of PerformCare staff responsible for all fraud, waste, and abuse, corporate compliance, HIPAA compliance, corporate integrity, as well as Federal and State regulations and requirements.

Fraud: Per CMS definition of Fraud and Abuse – Regulatory Citation 42 CFR 455.2 "fraud" is any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit for himself or some other person. It includes any act that constitutes fraud under applicable state or federal law.
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 DHS.
PerformCare Compliance Director: The PerformCare Compliance Director serves as the Compliance Officer for PerformCare and is responsible for monitoring of internal fraud, waste, and abuse. The Compliance Director is responsible for internal and external fraud, waste and abuse training. The Compliance Director ensures that contract obligations are monitored and met; serves as the privacy officer to ensure PerformCare adheres to HIPAA; and collaborates with Corporate Compliance on the employee code of conduct implementation.
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, is the overutilization of services, or other practices that result in unnecessary costs. Generally, it is not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Acronyms:
ACFC: AmeriHealth Caritas Family of Companies
BPI: Bureau of Program Integrity
CMS: Center for Medicare & Medicaid Services
DHS: Department of Human Services
FWA: Fraud, Waste and Abuse, as defined above.
HIPAA: Health Insurance Portability and Accountability Act
LEIE: List of Excluded Individuals and Entities, Federal Office of Inspector General
MFCU: Medicaid Fraud Control Unit
SAM: System for Award Management; office of General Services
SIU: Special Investigations Unit

Procedure:
1. PerformCare complies with the AmeriHealth Caritas Policy and Procedure 168.107 – The Corporate Compliance Program. PerformCare has established a Compliance Plan outlining those components not included in the AmeriHealth Caritas Policy. These documents describe the policies and procedures

utilized to ensure that PerformCare operates in accordance with all applicable federal and state rules and regulations, and in a manner consistent with administrative and fiduciary responsibility.

2. The PerformCare Compliance Plan and the AmeriHealth Policy and Procedure 168.107 Corporate Compliance Program will include, at a minimum all the requirements in CFR 438.608 (b) Program Integrity requirements.
3. In conjunction with the PerformCare Compliance Plan, PerformCare shall establish a Fraud, Waste, and Abuse Plan, see *Attachment 3*.
4. The Fraud, Waste, and Abuse Plan shall include the following required elements:
   - 4.1. The title and contact information of the FWA Coordinator.
   - 4.2. A description of specific controls in place for fraud, waste, and abuse detection, including an explanation of the technology used to identify aberrant billing patterns, procedures for claims, edits, post processing review of claims, review of complaints and grievances, and other means of identifying fraud, waste, and abuse.
   - 4.3. A description of the methodology and standard operating procedures used to investigate fraud and abuse, such as on-site visits and record reviews.
   - 4.4. A description of a methodology to require recipient verification of services billed to the Medicaid Program.
   - 4.5. Explanation of the process for referring suspected fraud and abuse to the DHS/BPI within thirty (30) business days of identification of the problem or issue.
   - 4.6. Methodology for recovering overpayments or otherwise sanctioning providers.
   - 4.7. Process for reporting to DHS in writing any providers who are suspended, resign, or voluntarily withdraw after initiation of fraud, waste, or abuse review.
   - 4.8. Process for reporting to DHS any provider who is denied credentialing or de-credentialed due to issues regarding fraud, integrity, or quality.
   - 4.9. A statement outlining an educational plan for staff relating to fraud, waste, and abuse. The employee education plan is annual and upon hire, and the training is documented and tracked by the corporation.
   - 4.10. A statement ensuring full cooperation with state and federal oversight agencies including, but not limited to, the BPI, the Governor’s Office of the Budget, the Office of Attorney General's Medicaid Fraud Control Unit, the Pennsylvania State Inspector General, the Federal Office

of Inspector General, and the United States Justice Department.

4.11. A statement that provides for the imposition of payment suspension at the request of DHS.

4.12. A statement of compliance with MA Bulletin 99-11-05.

4.13. The requirement of Quarterly Reporting (MCO/BPI Quarterly Report) submitted to DHS.

5. The PerformCare associate identifying the suspected violation will notify their supervisor and report the potential provider fraud, waste or abuse to the PerformCare 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) Make a referral to the SIU, following associate discussion with supervisor, regarding potential provider fraud, waste or abuse via email FraudTip@amerihealthcaritas.com
   (g) Speak with a member of the PerformCare Special Investigations Unit.
   (h) Referrals regarding potential Member fraud, waste or abuse or internal compliance issues are referred to the PerformCare Compliance Director via the methods listed above.
6. For provider referrals of alleged fraud, waste, and abuse the SIU Intake Team or designee will review the allegation referred to the SIU and will present the information to the Manager, Special Investigations Unit, for determination of whether the incident is reportable to the BPI, and will complete the referral form if appropriate. See *Attachment 1 MCO Fraud Waste and Abuse Reporting Requirements* and *Attachment 2 Checklist of Supporting Documentation for Referrals*.
7. The assigned SIU Clinical Investigator, or designee, will outline a course of action based on the particulars of the allegation. Actions may include the following:

   7.1. Requesting a claims report for the provider for specific Members included in the referral or for a specific time period,

   7.2. Completing a record request of the Members for the provider either identified in the original referral or of a statistically valid random sample of Members receiving services,

7.3. Review of clinical information pertaining to the identified Members or provider within the PerformCare data base,
7.4. Conduct an on-site audit to obtain requested records.
7.5. Based on a review of documentation and the PerformCare claims reporting, identify whether there is an overpayment of claims to the provider and draft a letter of the case findings to be sent to the provider and corresponding county oversight entity, the BPI, and the MFCU if necessary.

8. PerformCare SIU will cooperate with the Bureau of Program Integrity, the Attorney General's Office and other related entities if requested for any follow up actions.

Related Policies: *CC-001 Reporting Suspected Provider Fraud, Waste and Abuse*
CC-003 Provider Audits Conducted by the Special Investigations Unit
CC-004 Reporting Suspected Recipient Fraud, Waste and Abuse
QI-042 6-Criteria Complaint
QI-043 Dissatisfaction Complaint
QI-044 Grievance
168.107 The Corporate Compliance Program-AmeriHealth Caritas Family of Companies

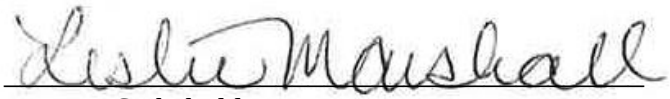
Related Reports: None

Source Documents and References: *Title 42 -Public Health §42 CFR Part 455.2*
Commonwealth of Pennsylvania Department of Human Services (DHS) HealthChoices Behavioral Health Program, Program Standards and Requirements

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 MCO Fraud, Waste and Abuse Reporting Requirements*
Attachment 2 Checklist of Supporting Documentation for Referrals
Attachment 3 FWA Plan

Approved by:



Primary Stakeholder

Attachment 1

MCO FRAUD AND ABUSE REPORTING REQUIREMENTS

1. Examples of Suspected Fraud and Abuse: The following are examples of suspected fraud and abuse that must be reported. The Primary Contractor or BH- MCO may reference 55 Pa. Code Sections 1101 et seq. and the specific regulations relating to each provider type for further guidance.

Billing / Record Keeping Issues

Falsifying/altering claims/ encounters/records
Upcoding / Incorrect coding
Double billing / Unbundling
Billing for services/ supplies not rendered / 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 ED visits; physician, pharmacy, or hospital "shopping"

Abuse of a Member

Physical, mental, sexual
Discrimination

Employee / Subcontractor Theft or Embezzlement

2. Reporting Suspected Provider Fraud and Abuse: The Primary Contractor or BH-MCO fraud and abuse unit must report suspected provider fraud and abuse within 30 business days of the discovery of the suspected fraud or abuse.

Reports are to be submitted online using the "MCO Referral Form." The instructions and form template are located on the HealthChoices extranet. Reports will be automatically referred to the Office of Attorney General and the Department.

Once completed, the form should be submitted electronically using DocuShare to BPI by clicking the "Submit" button. If DocuShare is inaccessible for any reason, the Primary Contractor or its BH MCO must notify the BPI contract monitor, then mail the supporting information to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

In addition to referrals to the Department, the Primary Contractor or BH-MCO is required to simultaneously submit fraud referrals directly to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as provided in 42 CFR §438.608(a)(7). Fraud referrals to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section shall be submitted by using the Department's BHMCO Referral Form. Fraud referrals submitted to the Department using the BHMCO Referral Form will be automatically forwarded by the Department to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section. After the referral form is submitted, the Primary Contractor or BH-MCO is required to upload the supporting documentation to the Department using DocuShare. The Primary Contractor or BH-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

3. Reporting Suspected Member Fraud and Abuse and requesting recipient restriction (lock-in) action: Report to:

DHS Bureau of Program Integrity Recipient Restriction Program
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717-772-4655 (fax)

4. Reporting Suspected Member Fraud and Abuse and not requesting recipient restriction (lock-in) action: Report to:

DHS Bureau of Program Integrity Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4655 (fax)

Attachment 2

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 recipient
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, 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 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 DME items
Other:

PerformCARE

PerformCare Corporate Fraud, Waste, and Abuse Plan

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PerformCare Corporate Fraud, Waste and Abuse Plan

Policy

In accordance with *CC-001 Reporting Suspected Provider Fraud, Waste, and Abuse*, PerformCare shall make every effort to prevent fraud, waste and abuse whether by providers, business associates, or by individuals within our own corporation. Further, PerformCare will implement policies and procedures to detect fraud, waste and abuse or improper claims practices, and will report violations to the Department of Human Services (DHS) Bureau of Program Integrity. PerformCare shall also ensure full cooperation with state and federal oversight agencies, including but not limited to the Bureau of Program Integrity, the Governor's Officer of the Budget, Office of the Attorney General's Medicaid Fraud Control Unit, the Pennsylvania State Inspector General, the Federal Office of the Inspector General, the US Justice Department, and law enforcement.

Provider fraud, waste and abuse include reports of physical/verbal abuse to a PerformCare HealthChoices Member, and any other provider actions that place the mental/physical health of the HealthChoices Member in jeopardy. These concerns are referred to the PerformCare Quality Improvement Department for follow up. Provider fraud, waste and abuse activities also include reports of alleged fraudulent billing and claims submissions or improper documentation of services delivered.

PerformCare views fraud, waste and abuse as a component of Compliance issues, and provides collaboration with the Fraud, Waste and Abuse Activities of the Amerihealth Caritas Special Investigations Unit (SIU) through the PerformCare Compliance Committee.

PerformCare and Amerihealth Caritas operate a toll-free telephone line (866-833-9718) to ensure the immediacy of provider/staff reporting of alleged or suspected fraud, waste and abuse violations. All pertinent calls should be referred to the SIU Manager (Fraud, Waste and Abuse Coordinator) or the PerformCare Compliance Director for further action.

Definitions

Abuse: Per CMS definition of Fraud and Abuse – Regulatory Citation 42 CFR 455.2 "abuse" is provider practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medical Assistance Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Alleged Violation: Receiving a report from a HealthChoices Member, employee of a provider, or from an associate of PerformCare who makes an accusation of violation with no hard evidence other than their verbal assertion (such as agency documentation) and the SIU has yet to conduct an audit or other investigation. Alleged violations of provider fraud, waste and abuse are referred to the SIU for further action and Member and/or internal FWA is referred to PerformCare Compliance for follow up.

Fraud: Per CMS definition of Fraud and Abuse – Regulatory Citation 42 CFR 455.2 "fraud" is any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit himself or some other person. It includes any

act that constitutes fraud under applicable state or federal law.
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, is the overutilization of services, or other practices that result in unnecessary costs. Generally, it is not considered to be caused by criminally negligent actions but rather by the misuse of resources

The Fraud, Waste and Abuse Coordinator

PerformCare will have an appointed full time Fraud, Waste and Abuse Coordinator (FWAC) with overall authority to enact this plan, and to represent PerformCare in any matters relating to Fraud, Waste and Abuse. The FWAC is a Manager of the SIU and an Amerihealth Caritas associate who oversees FWA operations for PerformCare. The FWAC will have demonstrated skills and experience in establishing a Fraud, Waste and Abuse Program, identifying instances of fraud, waste and abuse, and implementing Quality Improvement Plans, when necessary.

The PerformCare FWAC shall ensure that PerformCare providers comply with all Federal regulations and DHS mandatory or statutory regulatory requirements with respect to fraud, waste and abuse. The FWAC or designee shall prepare required reports and submit them to the PerformCare Executive Management for review, authorization, and transmission to the County Authority, licensed MCO, and the DHS as contractually obligated. The PerformCare FWAC is responsible for the submission of Quarterly Reporting (MCO/BPI Quarterly Report) to the BPI.

Erin O'Connor-Pritchard currently serves as the Fraud, Waste and Abuse Coordinator appointed by the HealthChoices counties, which contract to PerformCare for BH-MCO services.

Erin O'Connor-Pritchard
Manager, SIU/FWA Coordinator
Amerihealth Caritas - PerformCare
8040 Carlson Road
Harrisburg, PA 17112

Telephone: 717-671-6554
Fax: 717-671-6571
Email: eoconnor-pritchard@amerihealthcaritas.com

The SIU for PerformCare also includes Amy Martin, Clinical Investigator, and Mandi Fratini, Clinical Investigator.

Leslie Marshall currently serves as the PerformCare Compliance Officer. The PerformCare Compliance Officer ensures adherence to all Federal regulations and DHS mandatory or statutory regulatory requirements with respect to fraud, waste and abuse.

Leslie Marshall
Compliance Director
PerformCare
8040 Carlson Road
Harrisburg, PA 17112

Telephone: 717-540-1146
Fax: 717-909-2191
Email: lmarshall@performcare.org

Compliance Oversight of Fraud, Waste, and Abuse Investigations

PerformCare Compliance works collaboratively with the Amerihealth Caritas Program Integrity and the SIU. The Compliance Committee is charged with the responsibility for all fraud, waste and abuse, corporate compliance, HIPAA compliance, corporate integrity, as well as all Federal and State regulations and requirements. Compliance staff has had direct experience with investigations, and all staff receives continuing training in issues related to identifying fraud, waste and abuse, monitoring program integrity, code of conduct and privacy and confidentiality issues.

The PerformCare Compliance Committee consists of the following staff or their designee, by

position:

- Chair: Compliance Director
- Executive Director
- Director, Operations
- Director, Information Technology
- Director, Claims Management
- Director, Quality Improvement
- Director, Clinical Operations
- Manager, Contact Center
- Amerihealth Caritas Corporate Compliance Officer
- Amerihealth Caritas Associate Vice President, Corporate Audits/Investigations
- Director, SIU
- Manager, SIU/FWA Coordinator
- Medical Director
- HR Business Partner

At each quarterly meeting of the Corporate Compliance Committee, there are standing reports titled, the Provider Quarterly FWA Report and the FWA Summary, which summarize all active investigations or any situations that may require an investigation of fraud, waste and abuse for PerformCare.

Quality Improvement/Utilization Management Identification of Allegations of Fraud, Waste and Abuse

The Quality Improvement/Utilization Management Committee consists of senior staff and stakeholders representing the Counties, Oversight entities, Providers, and Consumer Advocacy Groups. It is the responsibility of the Committee to review, on a monthly basis, utilization data to determine trends and patterns. Reports are presented depicting utilization by type service and by providers.

The analysis of these reports is beneficial in identifying aberrant patterns by providers that may demonstrate a tendency to elevate type of service, or provide excessive units of service for particular diagnoses. Such trends are then reported to the PerformCare Compliance Committee, which may determine that an investigation is warranted. Further, the Compliance Committee may request that the SIU investigate allegations or explore suspicious patterns.

The Fraud, Waste and Abuse Team

PerformCare has a designated fraud, waste and abuse team, consisting of the following positions:

- Director, Compliance
- Executive Director
- AmeriHealth Vice President Corporate Compliance Officer
- Director, SIU
- Manager, SIU/FWA Coordinator

The SIU is charged with identifying, investigating, and reporting suspected fraud, waste, and abuse, inappropriate billing, and similar issues.

All PerformCare Associates have responsibilities for Fraud, Waste, and Abuse included in their job description to reflect responsibilities to report related FWA concerns. Following consultation with the associate's Supervisor/Manager/Director or the Compliance Director, if an FWA concern is noted, a referral should immediately be made to the SIU Team. This includes, but is not limited to:

- Director, SIU
- Manager, SIU/FWA Coordinator
- Clinical Investigator, SIU

Identifying Allegations of Fraud, Waste, and Abuse

Externally, allegations of fraud, waste and abuse are identified by providers, provider staff, county partners, Members, and other stakeholders affiliated with HealthChoices contracts. To promote the prevention and detection of fraud, waste, and abuse, PerformCare offers external training to all stakeholders using both a macro and micro approaches such as, education consults to specific providers and distribution of network clarifications on billing procedures. PerformCare expects providers to self-report allegations of fraud, waste and abuse, including overpayments, to PerformCare SIU within 72 hours of discovery, as per the Provider Handbook, as well as reporting to law enforcement, BPI, OAG or OIG.

Internally, allegations of fraud, waste, and abuse are identified through Member and provider contacts throughout all departments of the corporation. PerformCare trains all staff on the detection and reporting of fraud, waste, and abuse annually and at time of hire.

PerformCare is currently in the process of reviewing its software capabilities and that will further detect and/or deter internal and external fraud through pre-claim predictive analytics and data mining techniques. The PerformCare SIU utilizes GDIT/Cotiviti software with regard to an investigation database, claims audit, and query tool to enhance case progression. The SIU also uses a lead detection and pattern analysis tool that provides automated early-warning fraud and abuse detection and overpayment protection capabilities. Specifically, STARS Sentinel (Sentinel) is an early-warning detection system to flag providers and members who warrant investigation. Sentinel uses rules, algorithms, and pattern detection capabilities to evaluate, identify, compare, and rank providers and members who score on one or more rules or algorithms generating qualified leads for investigation. These algorithms are meant to identify potential fraud, waste, and abuse issues, including, but not limited to: duplicate claims, unbundling of services, or up coding of procedures.

PerformCare has consulted with experts in the field. Current capabilities are described below:

1. **Authorizations:** ***PerformCare's*** electronic medical records system – assists Clinical Care Managers in decision-making during the authorization process. Decisions are based on medical necessity criteria for each level of care as defined by OMHSAS. Clinical Care Managers are fully trained to consider medical and treatment history and follow-up if there are inconsistent patterns. Throughout the course of daily operations, if concerns are noted, potential referrals to the SIU are discussed with Supervisors/Managers to determine whether an SIU concern is apparent. Referrals can be made directly to the SIU as the need is indicated.

   For services which do not require authorization, it is required that the care be approved through a registration process that produces a record of authorization within

PerformCare's electronic medical records system**.** This allows system technology to track all treatment authorizations and episodes by time period. The Clinical Care Manager is therefore able to confirm that the level being requested represents continuity of care, and there are not inappropriate or conflicting episodes of care occurring during a specific time period

2. Procedures for Pre-Payment Claims Edits: Facets system has an auto- adjudication process that is employed for most claims. For a claim to be adjudicated as "clean" and therefore payable, it must first be matched with an authorization by provider

(If applicable), time period, and specific level of care. It must then pass the following edits:

- The procedure code is consistent with the level of care
- There is consistency with the provider's Medical Assistance ID Number, License, and procedure code as required by DHS
  NPI, Federal Tax Id and taxonomy are also required
- The claim is allowed for the specific level of care
- The location code is correct for the specific level of care.
- Member eligibility

3. Processing Review of Claims: Facets supports post-processing review of claims through its capacity to provide a broad spectrum of automated utilization management reports by provider, procedure, or any other specified criteria. In addition to the automated reports, the system accommodates system queries to identify post payment edits, such as:

- Up-coding
- Duplicate Billing
- Billing for Services Not Authorized or Not Performed

Prepayment Edits

- Billing for Partial Hospitalization and Other Services on the Same Day
- Billing for RTF and Other Services on the Same Day
- See *Attachment B*

4. Recipient Verification of Services: There are several existing processes in place for recipient verification of services. Primary among these is the PA Medicaid requirement for specific encounter forms to be signed by Members / Families. Encounter forms are required for multiple levels of care in the HealthChoices program and a sample is verified upon PerformCare treatment record reviews at provider sites as well as compliance audits. We also identify services received during the clinical care management authorization processes, as well as identify irregularities during the complaint and grievance process. In addition to these existing processes, PerformCare implemented the following quarterly process for recipient verification of services:

Random claim samples from defined high risk (e.g., home and community delivered) levels of care are generated on a rotating quarterly basis for each contract. Each contract will be sampled annually using a valid sample size.

A report is generated listing the random claims sample by Member for the preceding quarter and including the following minimum information:

- MA ID#

- Member Name
- Member DOB
- Provider Name
- Service Level Delivered and Paid
- Date of Service
- Units of Service Paid

The selection of Members will be randomized and generate a Mail Merge letter inclusive of the prior quarter's claims. Selected Members will receive a letter and the response process if services were not delivered as indicated. The SIU will investigate the allegations received from Members.

5. **Review of Complaints and Grievances:** PerformCare policies reflect the reality that indications of provider fraud may be received through a formal complaint/grievance process or through an informal personal or telephone contact. All employees, directors, and other agents of PerformCare are required to comply with CC-001 Reporting Suspected/Substantiated Provider Fraud, Waste and Abuse, which applies to complaints received through any process.

   The Complaint and Grievance Department, which reports directly to the PerformCare Quality Improvement Department, has promulgated CC-CG-001, Complaint Policy, CC-CG-004, Grievance Policy, which specify the process by which indications of fraud, waste, and abuse are referred for review. In all cases, the Fraud, Waste, and Abuse Coordinator will be responsible for the review, once the referral is submitted to the SIU. Standing Reports are presented to PerformCare Compliance Committee on Complaints and Grievances, and these would identify complaints about fraud, waste, or abuse.

6. **Quality Improvement Treatment Record Reviews:** Staff routinely review treatment records, on the PerformCare provider Credentialing schedule and as needed, and are trained to detect potential fraud, waste and abuse. As detected, providers are advised to review governing regulations and consider the need to return funds and/or self report, as stated in the PerformCare Provider Manual. Simultaneous referrals are also made to the SIU.

7. **Coordinated Studies:** PerformCare will comply with the Request for Proposals requirement to develop "procedures for the BH-MCO to collaborate with the PH-MCO in identifying and reducing the frequency of patterns of fraud, waste, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs."

8. **Office of Inspector General LEIE List; State Medicheck List; and System for Award Management (SAM formerly Excluded Parties List System (EPLS)):** PerformCare has developed a credentialing program in accordance with NCQA Standards and Department of Health requirements and includes verification that no providers credentialed to participate in the provider network have been sanctioned by Medicare or Medical Assistance. The National Practitioners Data Bank and Department of Health and Human Services are queried for sanctions by the AmeriHealth Caritas Corporate Credentialing Department upon the initial credentialing application and re-credentialing application. Re-credentialing occurs every three (3) years. Medicheck, OIG LEIE, SAM, NPPES and Death Master File are queried monthly to assure continuing compliance between credentialing and re-credentialing activities. PerformCare ensures compliance

with MA Bulletin 99-11-05. The PerformCare Credentialing Department reports to DHS in writing any providers who are suspended, resign, or voluntarily withdraw after initiation of fraud, waste and abuse review.

9. **CCM Utilization Audit:** CCM Documentation audits are completed on a monthly basis to ensure compliance with documentation of quality of care and treatment concerns. Results of the CCM Documentation audits are reviewed by clinical supervisors with CCMs individually in supervision and immediate opportunities for training are initiated, if needed.

10. **CCM Inter Rater Reliability:** PerformCare utilizes Inter-Rater Reliability vignettes to ensure consistency in decision-making when applying medical necessity criteria across Care Management staff on a semi-annual basis. Testing allows for consideration of qualitative and categorical variables by taking into account the level of agreement occurring by chance. Testing is conducted under the direction of the Medical director and the results are used to provide additional trainings, support, and individual supervision for Clinical Care Managers as needed.

Investigation of Fraud, Waste and Abuse

The PerformCare SIU will investigate all allegations of improper billing or alleged fraud, waste, or abuse. For each such investigation, there will be a detailed plan developed according to the following protocol. The SIU conducts data analysis of provider claim submission patterns, record reviews following requests of records from providers, as well as review of PerformCare documentation of Member care. The SIU also conducts interviews with staff onsite and will obtain Member records if necessary.

Incident Investigations External Audit Protocol:

- Identify the regulations and violation of the regulation under investigation,
- Specify the Audit Parameters, including what claims are subject to audit,
- Describe reports to be prepared prior to the audit,
- Specify documentation required for audit,
- Identify Member treatment records to be requested from the provider pertaining to the referral,
- Designate management and executive staff to be interviewed, if necessary,
- Provide specific "scripts" for questioning staff and Member/Guardians, if necessary,
- Establish process for scheduling visits, if necessary,
- Identify possible fraud scenarios to be reviewed,
- Designate what Member /Guardian will be interviewed, if necessary.

An Investigation Plan Protocol is included as Attachment A.

Reporting Suspected/Substantiated Provider Fraud, Waste, and Abuse

PerformCare Executive Management has approved CC-001 – Reporting Suspected/Substantiated Provider Fraud, Waste, and Abuse and the Policy has been submitted to and approved by the Bureau of Program Integrity. See Attachment B. PerformCare has incorporated the Department's MCO Fraud, Waste, and Abuse Reporting Requirements into this policy, which states:

Once the PerformCare Special Investigations Unit Manager has determined that the event meets the criteria of the Bureau of Program Integrity of DHS, the SIU Manager or designee will transmit required reports within thirty (30) days.

When a provider is suspended, resigns, voluntarily withdraws, or has any disciplinary action taken after initiation of fraud, waste, and abuse review, PerformCare follows its existing procedure to complete its investigation, regardless of the status of the provider. PerformCare Departments will make formal reports internally and to DHS/BPI of any provider who with draws or is terminated from our network due to fraud, waste or abuse investigation, as required by both BPI and PerformCare and reflected in policy CC-001 Reporting Suspected/Substantiated Provider Fraud, Waste, and Abuse.

The SIU will send all requested data to BPI or Attorney General's Office upon request.

The SIU and PerformCare will cooperate fully with oversight agencies including, but not limited to, the Department's Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania Office of the Inspector General, and the US Justice Department. Language supporting this statement is contained in CC-001 Reporting Suspected/Substantiated Provider Fraud, Waste and Abuse.

Recovering Overpayments or Otherwise Sanctioning Providers

The PerformCare provider agreement stipulates the methodology for recovering overpayment or otherwise sanctioning providers. Under this agreement, the provider agrees to return to PerformCare within 30 calendar days of demand issued by PerformCare and exhaustion of the provider dispute process (outlined in CC-005 Provider Dispute Policy) any funds previously overpaid to provider. The overpayment shall be returned to PerformCare within three hundred sixty-five (365) days of the date of the initial Overpayment Letter to the provider or as negotiated.

PerformCare may require recoupment of funds beyond three hundred sixty-five (365) days and will specify a means to set up a payment plan when requested by a provider. When PerformCare finds incorrect claims as a result of an allegation, PerformCare may retrospectively recoup funds up to four years before the date of the alleged waste or abuse named in the allegation and found in the review, which is consistent with the DHS. At the request of DHS, payment suspension for a provider can be imposed. PerformCare will place no time limit restrictions on the review or recoupment of funds to an alleged finding of fraud. Furthermore, the provider is required to make full and prompt restitution to PerformCare for any payments received in excess of amounts due under this agreement, whether such overpayment is discovered by DHS or PerformCare.

PerformCare may impose the following sanctions for noncompliance with any requirements under the Provider Agreement depending on the nature of the non-compliance:

1. Requiring the submission and implementation of a corrective action plan
2. Recoupment of improper claims
3. Suspension of additional referrals and authorizations for services;
4. Termination of the Agreement in accordance with Article IX.
5. Termination of all payments due to a credible allegation of fraud

Determination of the action to be taken will be made by PerformCare Executive Management on recommendation from the Credentialing Committee and/or external regulatory agencies. The applicable Primary Contractor(s) will notify BPI of the outcome.

Fraud, Waste and Abuse Staff Training

The SIU:
The Fraud, Waste, and Abuse Coordinator/Manager, SIU and SIU team will attend all periodic training and discussions as held by the Bureau of Program Integrity, and disseminate training material to staff as appropriate. The Fraud, Waste, and Abuse Coordinator/Manager, SIU and SIU team will attend trainings toward or to maintain certification within an accredited fraud investigation program. This can include, but is not limited to the Accreditation of Healthcare Fraud Investigations certification (AHFI) though NHCAA (National Health Care Anti-fraud Association) or the Certified Fraud Investigations certification (CFI).

Internal Staff Training:
PerformCare provides annual staff training on detecting and reporting allegations of fraud, waste and abuse and compliance. Staff training will include the following:

- Initial staff orientation at time of hire
- Annual corporate compliance and fraud, waste, and abuse and code of conduct
- Interdepartmental Trainings for staff regarding the SIU and Compliance Departments, the federal definitions of fraud, waste and abuse, steps to make a referral to the SIU or Compliance and contact information for the Compliance and SIU Departments and staff within each department. The trainings also provide specific compliance and fraud, waste, and abuse issues pertinent to the department participating in the training.

Provider Training:
PerformCare offers provider training via the provider handbook, provider conferences/webinars, provider education, and provider memos.

Member Opportunities:
PerformCare offers Members information to detect and report fraud via the Member handbook, Newsletters, and Parent Training Series.

Plan Approval

PerformCare has submitted its Fraud, Waste, and Abuse Plan and policies and procedures to all contract oversights, which have obtained the approval of the counties, who are the primary contractors.

1. **Duty to Report Suspected Fraud, Waste, and Abuse to the Department**
   PerformCare agrees to report all suspected fraud, waste, and abuse within thirty (30) business days, as described on page 10.

2. **Duty to Cooperate with Oversight Agencies**
   PerformCare will cooperate fully with oversight agencies including, but not limited to, the Department's Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania Office of the Inspector General, and the US Justice Department.

3. **Fraud, Waste, and Abuse Hotline**
   The Department's toll free fraud, waste, and abuse hotline and accompanying explanatory statement will be distributed to Members and providers through the Provider Agreement and the *Member Handbook.*

4. **Precluded Providers**
   Upon notification from the Department that a provider is terminated from participation in the Medicaid and Medicare programs, PerformCare will immediately act to terminate the provider from participation in its provider network.

5. **Provider Criminal Conviction**
   PerformCare will send all disclosed Provider criminal convictions information to the DHS's Bureau of Program Integrity within thirty (30) business days of disclosure.

Attachment A

PERFORMCARE SIU

Investigation Plan Protocol

External Audit Protocol

Audit Parameters

- Review PerformCare HealthChoices Members Only
- Review only services and claims submitted after 10/1/01
- Run a Provider Claims Report prior to on site audit
- Interview scripts will be completed prior to on site audit
- PerformCare SIU may conduct an unannounced audit, or
- Provider will be notified of audit time and date (during business hours), in announced visit
- PerformCare SIU may obtain list of all credentialed and approved clinical staff
- PerformCare SIU may obtain all medical records necessary for review from provider
- Provider will be notified of Management and Executive staff to be interviewed, in announced visit
- PerformCare will contact any Member that may need to be interviewed without notification to the provider agency

Examples

Scenario – Check agency policy and procedures to inform staff on changes to billing procedures

- Identify the service code descriptors given to staff.
- Review the instructions given to provide staff on coding and billing procedures
- Interview Supervisors of the Organization
    - Direct Supervisor
    - Regional Director/Department Head
    - Corporate Operations Director
    - Chief Executive Officer

- Corporate Compliance Officer

- Review the required agency policies
  - Corporate Compliance Plan
  - Written Billing Instructions
  - Schedule of Staff Meetings
  - Schedule of Team Meeting

Attachment B

Provider Notice

To:	**PerformCare Network Providers**
From:	**Director Operations**
Date:	**April 1, 2016**
Subject:	**AD 16 102 Additional Pre-Payment Claims Edits for Duplicate / Disallowed Services**

Certain claims edits, listed on the following pages, will become effective on May 2, 2016. These edits, which were previously resolved through a post-payment review process, will now be addressed prior to claim payment.

The edits are designed to address billing for duplicate or disallowed services. It is therefore important for providers to assess, prior to submitting a claim, whether certain services may be approved as adjunct services. In many cases, the services on the following list can be prior authorized as adjunct services via telephonic pre-certification through the Member's PerformCare Clinical Care Manager. If the additional services are prior authorized with PerformCare, payment will be approved to both services, assuming all other payment provisions are followed. It is important to note that these edits should be applied throughout the treatment episode. For example, for the duration of a treatment episode of Mental Health Partial Hospitalization, separate billing for outpatient Evaluation & Management visits are disallowed as the Member's medication management is to be delivered as part of the partial hospitalization service. On Remittance Advices, any clinically duplicative claims will have denial reason "Cost Avoid/Recovery – NCCI Edit."

For further detail pertaining to claims edits, please refer to (i) Provider Notice AD13 103R NCCI Claims Edits (11/1/13); (ii) Policy Clarification OC-16, Lab Charges during Substance Abuse Treatment (12/1/14); and (iii) SA 12 100 Substance Abuse Intensive Outpatient Program Expectations (2/13/12). These documents are available at:

http://pa.performcare.org/providers/resources-information/policies.aspx

Questions related to this Provider Notice and/or about specific disallowed CPT code combinations can be directed to your Account Executive.

Attachment B

IF a Member is in the following Mental Health (MH) Service:	THEN the following services are disallowed during the Tx Episode:
Assertive Community Treatment / Community Treatment Teams	MH Outpatient Diagnostic Evaluations MH Outpatient Therapies (individual, family, group) MH Outpatient E&M services
BHRS Mobile Therapy	MH Outpatient Therapies (individual, family)
CRR Host Home and CRR Intensive Treatment Program	MH Outpatient Therapies (individual, family)
Family Based Mental Health Services (FBMH)	MH Outpatient Therapies (individual, family, The Incredible Years)
Intensive Day Treatment (IDT), (exception service)	MH Outpatient Therapies (individual, family, group)
Juvenile Fire-setter Assessment Consultation Treatment Service (JFACTS)	MH Outpatient Therapies (individual, family)
Mobile Mental Health Therapy	MH Outpatient Therapies (individual, family, group)
Multi-systemic Therapy (MST)	MH Outpatient Therapies (individual, family, group)
MH Partial Hospitalization	MH Outpatient Diagnostic Evaluations MH Outpatient Therapies (individual, family, group) MH Outpatient E&M services
Residential Treatment Facility (RTF)	MH Outpatient Diagnostic Evaluations MH Outpatient Therapies (individual, family, group) MH Outpatient E&M services
MH Psychiatric Inpatient (including Extended Acute Care)	MH Outpatient Diagnostic Evaluations MH Outpatient Therapies (individual, family, group) MH Outpatient E&M services All Lab codes and physician consultation charges are disallowed as part of all-inclusive per diem unless specifically allowed by hospital contract.
Specialized In-Home Treatment Program (SPIN), (exception service)	MH Outpatient Therapies (individual, family, group)
Summer Therapeutic Activities Program (STAP)	MH Outpatient Group Therapy
Educationally-Integrated Behavioral Support Program (EIBS), (exception service)	MH Outpatient Diagnostic Evaluation (non-medical) MH Outpatient Therapies (individual, family, group)
Psychiatric Rehabilitation, Site Based	Mobile MH Treatment services

IF a Member is in the following Substance Abuse (SA) Service:	THEN the following services are disallowed during the Tx Episode:
SA Inpatient and Non-Hospital Detoxification, Residential Rehabilitation and Halfway House	All Lab codes and physician consultation charges are disallowed as part of all-inclusive per diem unless specifically allowed by provider contract*
SA Intensive Outpatient Program (IOP)	SA Outpatient Therapies (individual, family, group), whether provided at same or different providers*
Methadone Maintenance	All Lab codes are disallowed during the duration of treatment except as allowed by regulation. (See PerformCare Policy Clarification PC-16)* SA Outpatient Therapies (individual, family, group), whether provided at same or different providers*
SA Partial Hospitalization	SA Outpatient Therapies (individual, family, group), whether provided at same or different providers

*These disallowed services have been identified as high risk areas for providers that have been subject to previous recovery of funds. Please evaluate Members in treatment for concurrent services. Prior authorization would be required for continuation of disallowed therapy services.

cc: Scott Suhring, Capital Area Behavioral Health Collaborative
Missy Reisinger, Tuscarora Managed Care Alliance
Lisa Hanzel, PerformCare Executive Director
PerformCare Account Executives