HCCA

P14 Discover How Managed Care Plans are Responding to their Obligations in Detecting, Investigating and Preventing Fraud and Abuse in the Health Care System

Sunday, March 26, 2017 9AM to 12AM

Mary Beach
Caron Cullen
Katherine Leff
Bernadette Underwood

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AGENDA

- SIU Mission
  - FWA Prevention
  - FWA Identification
  - FWA Investigation
  - Correction
  - Reporting
- Program Integrity/Compliance

2

SIU MISSION

3

FWA PREVENTION

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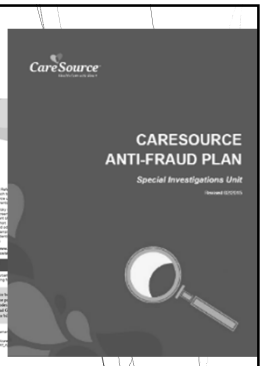
PREVENTION

Education & Training

- Members
- Providers
- Employees



- Training Programs
- Website
- Member/Provider Manuals
- Newsletters
- Anti-fraud Plan
- OIG Links

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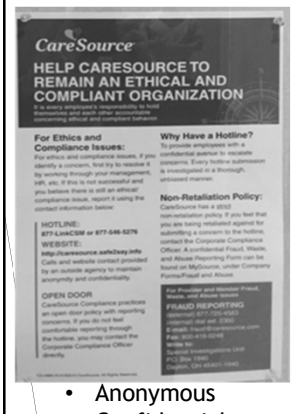
PREVENTION

Reporting Mechanisms

- FWA Hotlines
- Ethics & Compliance Hotlines



- Anonymous
- Confidential
- Non-retaliation

Posters
Intranet Site
Badges
Website

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PREVENTION

Programs

- Clearinghouse Instructions
- Coding Assist
- Clinical Edits
- Provider Education Letters
- Provider Pre-pay review
- Claim Line Pre-pay Review

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Clinical Edits

- Clinical editing rules
  - Rebundle
  - Duplicates
  - Modifiers
  - Mutually Exclusive
  - Invalid Coding
- Edits customized per line of business

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Clearinghouse

- Duplicates
- Patient sex and surgical procedure do not match
- Member mismatch

Coding Assist

- Peer Comparison base line
- Send claim back to provider in clearinghouse with notification of aberrancy
- Follow with letter to provider
- Certified coder calls provider
- Monitor for billing behavior change

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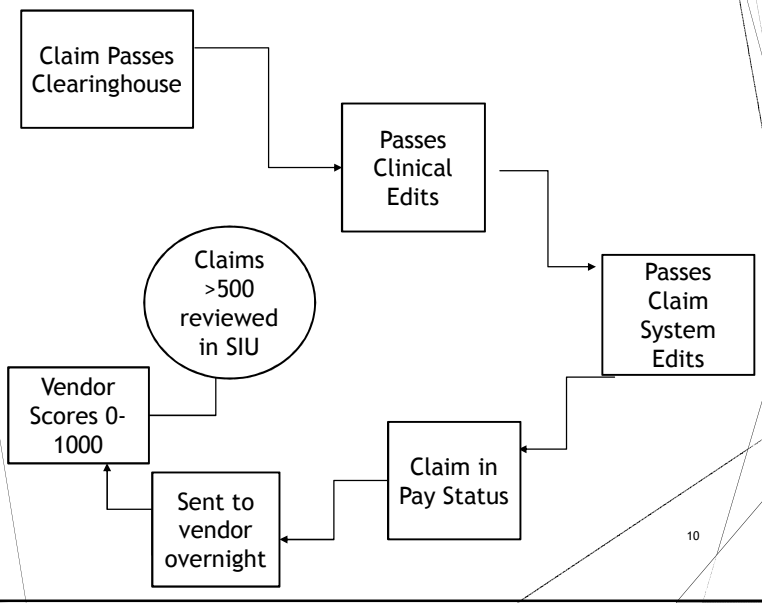
Claim Line Pre-pay Review



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Provider Education Letter

To whom it may concern:

As part of our ongoing process to identify fraud, waste, and abuse in the healthcare system, CareSource may periodically conduct an audit of medical claims data.

During a recent review of medical claims data, a pattern of unbundling ophthalmic exams and refractive services was noted. CareSource policy, which follows CMS guidelines, states that when the refractive service (92015) is performed during a routine eye exam (e.g., CPT codes 92002, 92004, 92012, 92014); the refraction is considered part of the exam and is not separately reimbursable.

Please reference CareSource Network Notification dated October 28, 2011 regarding the CareSource refraction policy. For your convenience, the notification is included with this letter.

This letter is being sent for educational purposes in the hopes that the areas of concern highlighted will be addressed by your practice.

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Peer Comparison Chart

CareSource

CareSource Ohio
CFC Eval and Management Peer Comparison
Dr [redacted]
August 1, 2015 – August 1, 2016
As of August 10, 2016

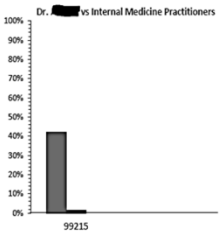
State of [redacted]

ABD
Established Patient

	99215
Dr [redacted]	42.0%
Internal Medicine Practitioners	1.5%
Number of Claims	1,822
Unique Members	1,220

Comparison based on 384 peers

Dr. [redacted] vs Internal Medicine Practitioners

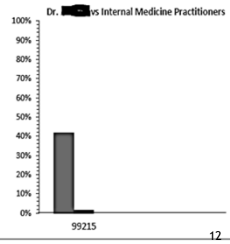


CFC
Established Patient

	99215
Dr. [redacted]	41.9%
Internal Medicine Practitioners	1.3%
Number of Claims	6,165
Unique Members	4,416

Comparison based on 733 peers

Dr. [redacted] vs Internal Medicine Practitioners



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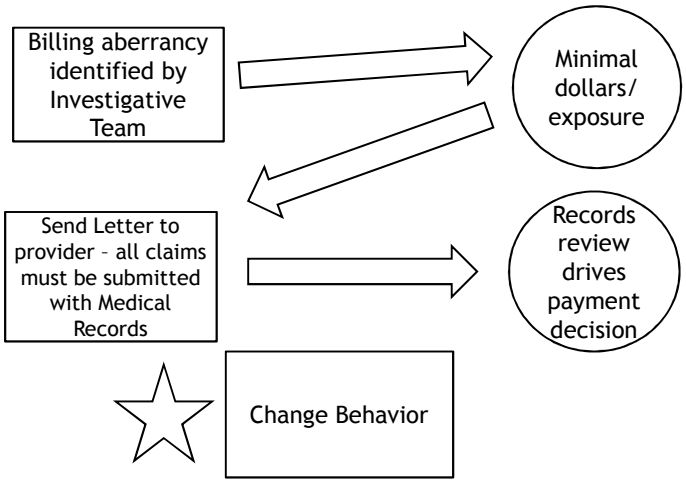
Provider Pre-Pay Review



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PROVIDER PREPAY NOTIFICATION LETTER

[DATE]

[PROVIDER GROUP NAME]
[PROVIDER NAME]
[ADDREESS]
[CITY, STATE, ZIP]

Dear Provider,

Please be advised that CareSource has implemented Prepayment Review of your Medicaid claims.

CareSource is mandated by the Centers for Medicare and Medicaid Services to have an effective surveillance and utilization program that safeguards against unnecessary and inappropriate use of Medicaid services and overpayment of services. In addition, in an effort to safeguard the Medicaid program, your state office for Program Integrity requires a continuum of activities to be carried out, including pre-payment review.

Our team will be evaluating various sources of information for risk related practices. Prepayment reviews look for overutilization of services or other practices that, directly or indirectly, result in unnecessary cost to the health care industry. Examples include but are not limited to: selection of the wrong CPT, HCPCS, ICD-10 code/s for services or supplies, lack of documentation in the medical record to support services billed, billing for items or services that should not or were not provided based upon documentation in the medical record. These audits can also confirm appropriate utilization of cost effective supplies and substantiating documentation to support services provided to the member. Based upon the finding of our evaluation, you have been selected for a comprehensive medical review.

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Prepayment Review of Medicaid claims is not a sanction and is not subject to appeal. Charges for services that do not meet guidelines for reimbursement will be subject to denial.

Prepayment review will be implemented beginning on [DATE] for those claims with date of service beginning [DATE] that have not yet been paid or submitted. All claims must now be submitted with appropriate supporting documentation (including but not limited to: office notes, individualized treatment plans, operative reports, office procedures and testing results).

During the time that you are on Prepayment Review please be advised that any claim submitted without the required documentation will be denied. Should additional records be required to support services billed, you will be notified via letter and will have 30 days to submit the additional requested documentation. If CareSource is not in receipt of the additional documentation within 30 days from date of notification letter, the entire claim will be denied.

Please ensure that all documentation sent to CareSource is in paper format and photocopied as single-sided copies to the following address:

CareSource
Attention Prepayment Review Team
PO Box XXXX
Dayton, Ohio 45401-XXXX

Please do not submit appeal requests until claim has been processed and decisioned.

If you have any question about submission of claims, please contact ------- via email to ----------@CareSource.com or via phone to (937) --- - ----.

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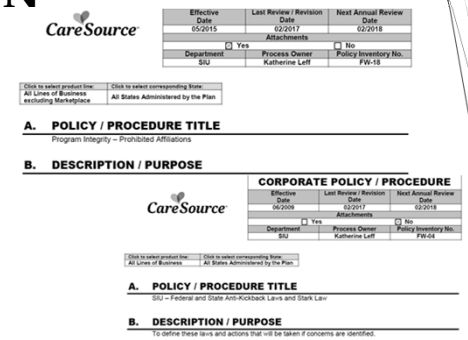
Sincerely,

CareSource Provider Pre-Pay Team

PREVENTION

Federal Laws

- False Claims Act
- Prohibited Affiliations
- Disclosures
- Stark – Physicians Self-Referral
- Anti-kickback
- Civil Monetary Penalties
- Criminal Health Care Fraud Statute



CareSource

Effective Date	Last Review / Revision Date	Next Annual Review Date
05/2015	02/2017	02/2018
Attachments		
☐ Yes		☐ No
Department	Process Owner	Policy Inventory No.
SIU	Katherine Leff	FW-18

Click to select product line:	Click to select corresponding State:
All Lines of Business excluding Marketplace	All States Administered by the Plan

A. POLICY / PROCEDURE TITLE
Program Integrity – Prohibited Affiliations

B. DESCRIPTION / PURPOSE

CORPORATE POLICY / PROCEDURE

CareSource

Effective Date	Last Review / Revision Date	Next Annual Review Date
06/2009	02/2017	02/2018
Attachments		
☐ Yes		☐ No
Department	Process Owner	Policy Inventory No.
SIU	Katherine Leff	FW-04

Click to select product line:	Click to select corresponding State:
All Lines of Business	All States Administered by the Plan

A. POLICY / PROCEDURE TITLE
SIU – Federal and State Anti-Kickback Laws and Stark Law

B. DESCRIPTION / PURPOSE
To define these laws and actions that will be taken if concerns are identified.

EXCLUSION FROM PARTICIPATION IN ALL FEDERAL HEALTH CARE PROGRAMS

State Laws

- False Claims Acts
- Fraud Statutes

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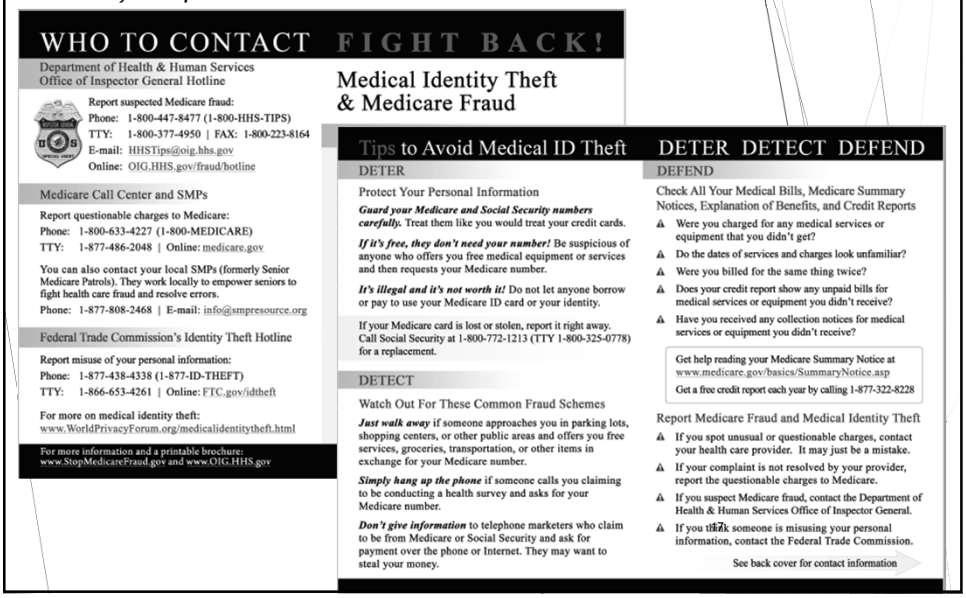
PREVENTION

Identity Theft



WHO TO CONTACT

Department of Health & Human Services
Office of Inspector General Hotline

Report suspected Medicare fraud:
Phone: 1-800-447-8477 (1-800-HHS-TIPS)
TTY: 1-800-377-4950 | FAX: 1-800-223-8164
E-mail: HHSTips@oig.hhs.gov
Online: OIG.HHS.gov/fraud/hotline

Medicare Call Center and SMPs

Report questionable charges to Medicare:
Phone: 1-800-633-4227 (1-800-MEDICARE)
TTY: 1-877-486-2048 | Online: medicare.gov

You can also contact your local SMPs (formerly Senior Medicare Patrols). They work locally to empower seniors to fight health care fraud and resolve errors.
Phone: 1-877-808-2468 | E-mail: info@smpresource.org

Federal Trade Commission's Identity Theft Hotline

Report misuse of your personal information:
Phone: 1-877-438-4338 (1-877-ID-THEFT)
TTY: 1-866-653-4261 | Online: FTC.gov/idtheft

For more on medical identity theft:
www.WorldPrivacyForum.org/medicalidentitytheft.html

For more information and a printable brochure:
www.StopMedicareFraud.gov and www.OIG.HHS.gov

FIGHT BACK!

Medical Identity Theft
& Medicare Fraud

Tips to Avoid Medical ID Theft

DETER

Protect Your Personal Information

Guard your Medicare and Social Security numbers carefully. Treat them like you would treat your credit cards.

If it's free, they don't need your number! Be suspicious of anyone who offers you free medical equipment or services and then requests your Medicare number.

It's illegal and it's not worth it! Do not let anyone borrow or pay to use your Medicare ID card or your identity.

If your Medicare card is lost or stolen, report it right away. Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) for a replacement.

DETECT

Watch Out For These Common Fraud Schemes

Just walk away if someone approaches you in parking lots, shopping centers, or other public areas and offers you free services, groceries, transportation, or other items in exchange for your Medicare number.

Simply hang up the phone if someone calls you claiming to be conducting a health survey and asks for your Medicare number.

Don't give information to telephone marketers who claim to be from Medicare or Social Security and ask for payment over the phone or Internet. They may want to steal your money.

DETER DETECT DEFEND

DEFEND

Check All Your Medical Bills, Medicare Summary Notices, Explanation of Benefits, and Credit Reports

- Were you charged for any medical services or equipment that you didn't get?
- Do the dates of services and charges look unfamiliar?
- Were you billed for the same thing twice?
- Does your credit report show any unpaid bills for medical services or equipment you didn't receive?
- Have you received any collection notices for medical services or equipment you didn't receive?

Get help reading your Medicare Summary Notice at
www.medicare.gov/basics/SummaryNotice.asp
Get a free credit report each year by calling 1-877-322-8228

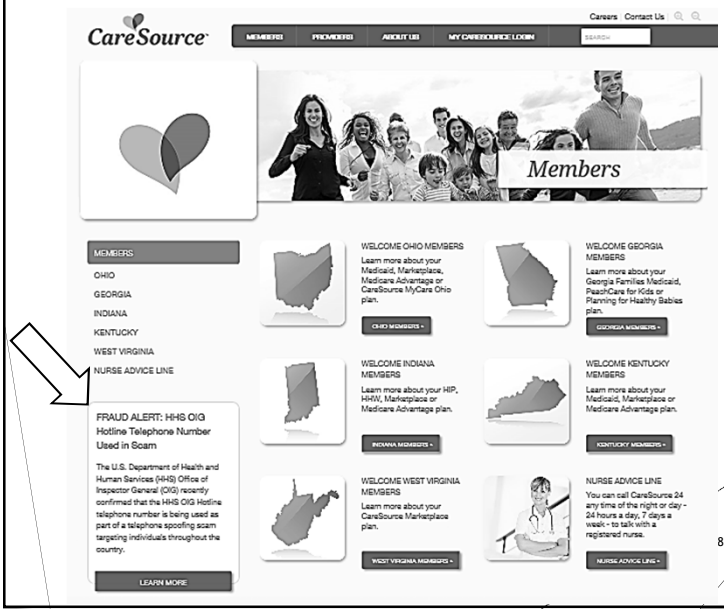
Report Medicare Fraud and Medical Identity Theft

- If you spot unusual or questionable charges, contact your health care provider. It may just be a mistake.
- If your complaint is not resolved by your provider, report the questionable charges to Medicare.
- If you suspect Medicare fraud, contact the Department of Health & Human Services Office of Inspector General.
- If you think someone is misusing your personal information, contact the Federal Trade Commission.

See back cover for contact information

PREVENTION

Fraud Alerts



CareSource

Careers Contact Us

MEMBERS PROVIDERS ABOUT US MY CARESOURCE LOGIN

SEARCH

Members

MEMBERS

OHIO

GEORGIA

INDIANA

KENTUCKY

WEST VIRGINIA

NURSE ADVICE LINE

FRAUD ALERT: HHS OIG Hotline Telephone Number Used in Scam

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently confirmed that the HHS OIG Hotline telephone number is being used as part of a telephone spoofing scam targeting individuals throughout the country.

LEARN MORE

WELCOME OHIO MEMBERS

Learn more about your Medicaid, Marketplace, Medicare Advantage or CareSource MyCare Ohio plan.

OHIO MEMBERS >

WELCOME GEORGIA MEMBERS

Learn more about your Georgia Families Medicaid, PeachCare for Kids or Planning for Healthy Babies plan.

GEORGIA MEMBERS >

WELCOME INDIANA MEMBERS

Learn more about your HIP, HHW, Marketplace or Medicare Advantage plan.

INDIANA MEMBERS >

WELCOME KENTUCKY MEMBERS

Learn more about your Medicaid, Marketplace or Medicare Advantage plan.

KENTUCKY MEMBERS >

WELCOME WEST VIRGINIA MEMBERS

Learn more about your CareSource Marketplace plan.

WEST VIRGINIA MEMBERS >

NURSE ADVICE LINE

You can call CareSource 24 any time of the night or day - 24 hours a day, 7 days a week - to talk with a registered nurse.

NURSE ADVICE LINE >

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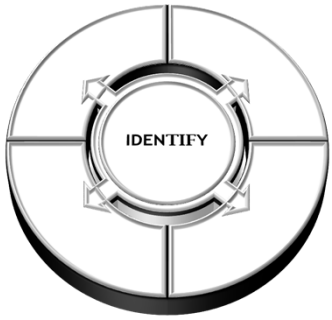

FWA IDENTIFICATION

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Creating an Effective Program Integrity Program - Stakeholders

Internal

FWA Awareness and Collaboration

Compliance Department
- Fraud Helpline (internal and external)
- Fraud Tips
- PCO and RMM collaboration

Pharmacy
- PBM
- Audits/investigations

Provider Contracting
- Credentialing
- Sanctioned Providers

Health Care Analytics
Anti-Fraud Tools

Health Plan
- HP Leadership
- Gov't Relations
- Provider Relations
- HCMS

Clinical Services
- Appeals and grievances
- Medical Directors
- Quality of care issues
- Coding and policy changes

External

Monitoring and Intelligence Gathering

NHCAA
- Latest schemes and trends
- Fraud Alerts
- SIRIS database

HHS-OIG
- Referrals
- Sanctioned List
- Enforcement Database
- Fraud Alerts
- Task Force referrals

HEAT Strike Force
- Enforcement Activity

Attorney General (AG)
- Insurance Fraud Division
- Medicaid Fraud Control Unit

State Regulatory Agency
- Program Integrity

CMS
- Health Integrity Referrals
- Part C & D Work Group meetings
- Fraud Alerts MEDIC
- HFPP

FBI
- Task Force
- Private Health Care Fraud

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Internal Identification Sources

- Compliance
  - Fraud Hot Line – Internal and External
  - Associate FWA Training
- Provider Contracting
  - Credentialing
  - Sanctioned Providers
- Health Plan
  - Government Relations
  - Provider Relations
  - Health Care Management Services

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Internal Identification Sources

- Pharmacy
  - PBM
- Clinical services
  - Appeals and Grievances
  - Medical Directors
  - Quality of Care Issues
  - Coding and Policy Changes
- Health Care Analytics
  - Costs Containment

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Internal Identification Sources

- Special Investigations Unit
  - Anti-Fraud Tools
    - Post-payment Review
    - Pre-payment Review

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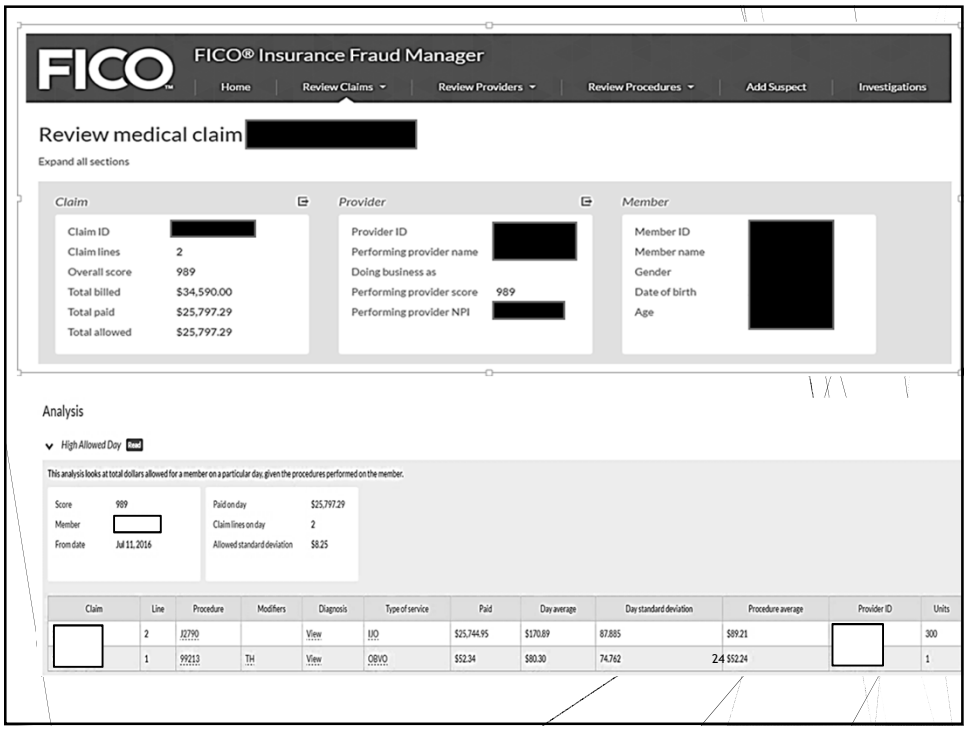

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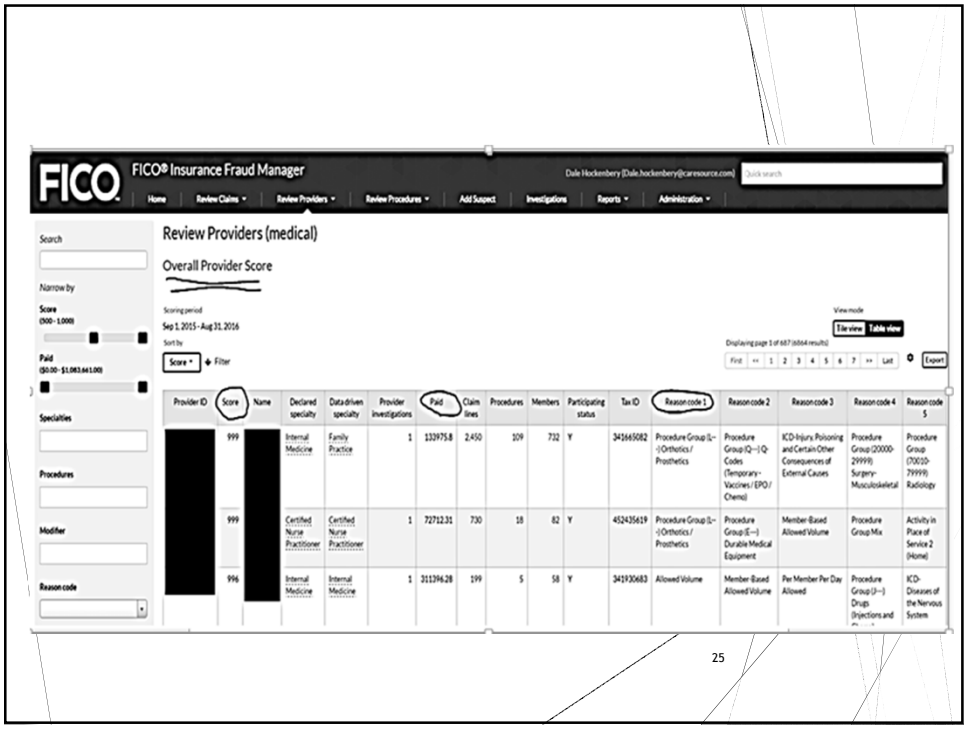

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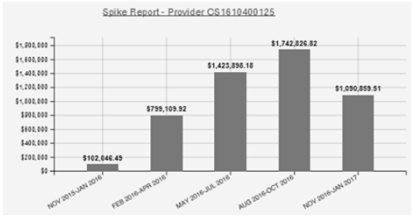
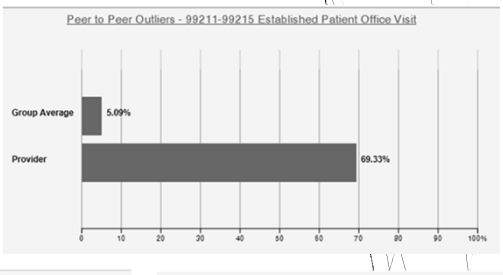
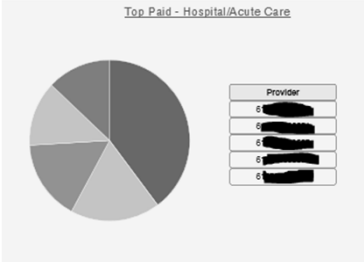
LEXIS POST-PAY





Rule Spotlight - DMERR001 - Possible excessive rental DME charges

	Provider ID	CLI	Flag Count	Provider Charged Amount	Provider Paid Amount
1	[redacted]	77	416	$1,419,180.00	$1,243,534.26
2		80	4,402	$1,994,488.30	$845,634.64
3		80	4,842	$1,858,640.10	$791,090.00
4		78	596	$465,234.70	$226,727.40
5		67	128	$207,965.76	$155,798.12
6		67	460	$157,986.10	$70,599.00
7		61	65	$107,300.00	$58,931.96
8		70	37	$108,256.00	$53,429.00
9		69	74	$107,532.41	$50,599.60
10		64	714	$153,041.96	$50,259.89



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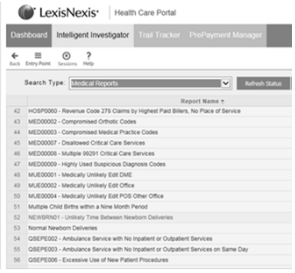
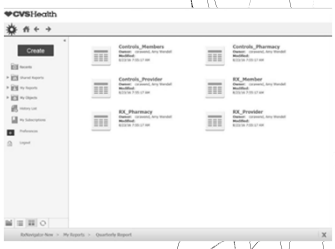
DATA ANALYTICS



Numerous Reports

HFPP – Numerous Studies



Pharmacy
Controlled substance
High utilization reports

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CASE TRACKING SOFTWARE

Dashboard

Case Details

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External Identification Resources

- NHCAA
  - Latest Schemes and Trends
  - SIRIS Database
  - Training Opportunities
- Health and Human Services – Office of Inspector General
  - Sanctioned List
  - Fraud Alerts
  - Task Force Referrals

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External Identification Resources

- State Regulatory Agencies
  - Program Integrity Unit
  - Insurance Fraud Division
  - Medicaid Fraud Control Unit
- CMS
  - MEDIC Fraud Alerts
  - Part C & D Work Group Meetings
- FBI
  - Task Force Meetings

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External Identification Resources

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Source: Medicare Fraud Strike Force, HHS Office of Inspector General, https://oig.hhs.gov/fraud/strike-force/

External Identification Resources

Healthcare Fraud Prevention Partnership

The HFPP began in 2012 and started with approximately 20 Partners.

Today the HFPP has grown to 75 Partners, including federal agencies; private payers; and anti-fraud, waste, and abuse associations.

Healthcare Fraud Prevention Partnership

- Studies & Algorithms
- In-person regional information sharing sessions
- Real-time provider alerts
- Fraud scheme notifications

Healthcare Fraud Prevention Partnership (HFPP)

7 Federal Agencies	40 Private Plans	11 Associations	17 State & Local Partners
• Department of Defense, Defense Health Agency • Department of Health and Human Services (HHS), Associate Deputy Secretary's Office • Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) • Department of Health and Human Services, Office of the Inspector General (HHS OIG) • Department of Justice (DOJ), Criminal Division • Department of Justice, Federal Bureau of Investigation (FBI) • United States Department of Veterans Affairs (DVA)	• Aetna • Amerigroup • Anthem • AvMed • BCBS of Alabama • BCBS of Kansas • BCBS of Louisiana • BCBS of Nebraska • Blue Shield of California • CareFirst Blue Cross Blue Shield • Care Source • Centene • Central Health Plan of California • Cigna • Emblem Health • Fidelis Care NY • Florida Blue • Geisinger Health Plan • Health Alliance Plan • Healthfirst, Inc. • Health Care Service Corporation (HCSC) • HealthSun • Highmark • Horizon BCBS of New Jersey • Humana • Independence Blue Cross • Kaiser Permanente • Magellan Health • Medical Mutual of Ohio • MediGold • ModaHealth • Molina Healthcare • Premera Blue Cross • SCAN Health Plan • Sentry • The Hartford • Travelers • Tufts Health Plan • United HealthCare • Wellcare	• America's Health Insurance Plans (AHIP) • American Insurance Association (AIA) • Blue Cross and Blue Shield Association (BCBSA) • Coalition Against Insurance Fraud (Coalition) • Delta Dental Plans Association • National Association of Insurance Commissioners (NAIC) • National Association of Medicaid Directors (NAMD) • National Association of Medicaid Fraud Control Units (NAMFCU) • National Business Group on Health (NBGH) • National Health Care Anti-Fraud Association (NHCAA) • National Insurance Crime Bureau (NICB)	• Arkansas: Office of the Medicaid Inspector General • Arizona: Medicaid Office of the Inspector General, Arizona Health Care Cost Containment System • California: Department of Healthcare Services • Connecticut Department of Social Services • Illinois: CountyCare, Cook County HHS • Illinois: Department of Healthcare and Family Services Office of Inspector General • Iowa: Insurance Fraud Bureau (NAIC's representative on the Information Sharing Committee) • Maryland: Department of Health and Mental Hygiene • Massachusetts: Office of the State Auditor • New York: Office of Medicaid Inspector General • North Carolina: Department of Health and Human Services, Division of Medical Assistance • Ohio: Attorney General's Office (NAMFCU's representative on the Information Sharing Committee) • Ohio Department of Medicaid • Oregon Health Authority • Texas: HHS Commission Office of Inspector General • Vermont: Program Integrity Unit, Dept. of Vermont Health Access • West Virginia: Bureau for Medical Services

Current Membership is at 75 Partners

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FWA INVESTIGATION

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Investigative Process

- After a concern or issue is identified, then what?
- The investigation begins but…
- What are we looking for?

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WHERE DO WE START?

- Gather information!
- What kind of information?
- How do we determine if there is a credible allegation or evidence of fraud?

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DEFINITION:CREDIBILITY
Merriam Webster Dictionary

1: the quality or power of inspiring belief

2: capacity for belief

3: the quality of being believed or accepted as true, real, or honest

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CREDIBLE EVIDENCE
The legal definition

Credible evidence is not evidence which is necessarily true, but is evidence worthy of belief, that is, worthy to be considered by the jury. It is often natural, reasonable and probable as to make it easy to believe.

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GATHER PRELIMINARY INFORMATION (1)

- What does that look like?
- Who is involved? Provider/member/vendor.
- What is the specific issue or allegation fraud or abuse?
- What is available that makes you think there is a concern?

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GATHER PRELIMINARY INFORMATION (2)

- How much exposure does the Plan have?
- How urgent the situation is? Is there potential member harm?
- Based upon these answers, you may proceed in various ways.

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DO YOU HAVE CREDIBLE EVIDENCE TO PROCEED?

- NO. What actions do you take now?
- YES. Proceed with a Comprehensive Investigation.

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GATHER COMPREHENSIVE INFORMATION

- Review the provider / member/vendor files
- Pull 3 to 6 years of comprehensive paid and denied claims
- Research the medical necessity, CPT code and the regulation
- Determine if other providers / members are involved
- Interview the person submitting the allegation if possible

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GATHER COMPREHENSIVE INFORMATION

- Obtain medical records for analyzing
- Perform a service verification call
- Possible surveillance & onsite visit
- Prior internal complaints or external complaints documented from state of federal agencies,
- Online sources such as the internet, Facebook, LinkedIn, etc.,

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Gather Information…

- This investigative stage may also include: interviewing relevant parties such as the provider or member, obtaining signed statements from witnesses or the subject of the investigation, and reviewing a sampling of claims data.
- Review internal systems to assure it has been configured correctly (really a preventative step).

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Gather Information…

- Any action taken in the investigation stage, whether it is requesting medical records, conducting an interview, completing a telephone call, or requesting claims reports, must be documented in the case files.

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Is There Credible Evidence to Proceed?

- NO. What actions do you take now? Let it go…
- YES. Proceed with an evaluation of the facts.

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EVALUATING the INFORMATION

- What conclusions may you draw from the information and whether we have a potential FWA case or not?
- Some questions to consider: What does the information and data tell us?
  - Is there reasonable explanation for the situation or behavior that was suspected as fraudulent or abusive?
  - Would this medical treatment for this diagnosis be consistent with acceptable medical practices?
  - Do you have a statement from an independent clinician to state a contrary position?
  - What is the provider's explanation?

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QUESTIONS TO CONSIDER…

- Do we have any admission of guilt by the member or provider?
- Do we have signed statements from relevant parties, i.e., from a member, to state that the member never received the service billed?
- Is this information reliable?
- Do other factors come into play, e.g., has the member ever been diagnosed with dementia?
- Does the claim data support the allegation of inappropriate billing?
- Do you have enough information to make a decision? If so, what is the decision and what are your next steps? If not, what other information would be helpful to make a decision? Is the information available?

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REAL LIFE STORIES
Provider A

Optical

- Exposure: $ 250,000
- Scheme: unlawfully used various providers NPI / EIN to create contracts with various MCO's in NYC and they also used the provider's information to open bank accounts / furnish the office with the best equipment available. With the help of a billing agency they managed to obtain member information to falsify medical records / claims. In this case, we were unable to directly recovery the funds as the provider was indicted.
- Civil law suit.

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REAL LIFE STORIES
Provider B

Pain Management

- Exposure: Significant Member Harm
- Scheme: Provider refused to bill health plan, required members to pay $150 or $200 cash per "office visit." The only service was to write a RX for controlled substances (suboxone, methodone). An E/M visit for substance use is a Medicaid covered service; member billing is prohibited.
- Initial overpayment recovery is to make the members whole.
- This case is still open pending responses from NY Office of Medicaid Inspector General (OMIG) and NY Office of Professional Medical Conduct (OPMC), Drug Enforcement Agency (DEA).

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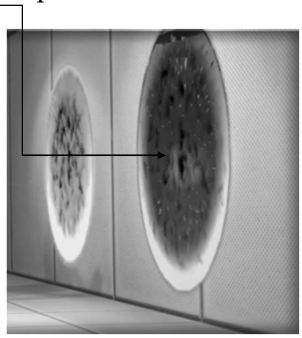
REAL LIFE STORIES
Providers C and D

Examples

- Mama bought me a CT Scanner –
  - 6.5 Years in prison
- Tiptoeing through the portal



Member eligibility

Guess at member names

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INVESTIGATE

Case Tracking Software

Triage
- Data analytics
- Research
- Limited medical records request
- Interviews
- Provider education
- Case assessment
- Close case or move to investigation

Investigation
- Review Triage findings
- Report FWA to appropriate agencies
- Investigative plan
- Background checks
- Data analytics
- Interviews
- Social Media
- Medical record SVRS request
- Medical/Coding experts
- Onsite audit/review and interviews
- Law Enforcement/State Agency Collaboration
- Recommend Corrective Actions to Investigation Committee

Investigation Committee
- Present evidence
- Discuss member impact
- Approve action or require more information

Compliance Committee · Board Audit and Compliance Committee
- Identify Risks
- Report Actions

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CORRECTION

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Correct!

Provider

RECOVERY

LEGAL ACTION

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Correct for whom?

- Plan – Do we help or hurt?
- Providers – Primary Concentration
- Members – What are State or Federal guidance?
- Employees – Collaboration with HR
- Vendors – Collaboration with Contracting / Other Operational Areas

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Plan Issues

- Is your claims processing system configuration appropriate?
- What has the Plan done to contribute to potential issues?

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Provider Training & Education

- Arrange for specific training of the provider and office staff for the identified issue.
- If you are seeing trends, offer periodic coding classes, or newsletters, or faxblast to all offices

When:

- If it appears to be a lack of understanding
- If this has not been a recurring theme with this provider's claims

Provider

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Provider on Review

For the claims in questions, consider:

- Require authorizations for all services in question, or
- Review claims prior to the release, or
- Request medical records for all cases.

When:

- The issue keeps appearing and perhaps training and education did not make a difference.

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Provider Limitations

- Close Providers Panel to New Membership
- Limit availability of Provider to members.

When:

- You are working with provider to resolve issues.
- You feel it is somewhere between errors and perhaps abusive practices.

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Provider Overpayment Recovery

Consider: What claims will be processed, paid, and denied going forward? What action is needed to address past claims. Actions will vary.

- Request a refund on claims/issues in question
- Withhold the payment of future claims to recover overpayments
- Negotiate a settlement amount

When:

You reach a conclusion that the claims were paid incorrectly and/or should not be paid going forward.

RECOVERY

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Provider Auditing

"Auditing is a formal, systematic and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited, and normally performed by individuals with one of several acknowledged certifications. Objectivity in governance reporting is the benefit of independence."

Source: Defining the Meaning of Auditing and Monitoring & Clarifying the Appropriate Use of the Terms, by Mark P. Ruppert, CPA, CIA, CISA, CHFP. Accessed at: https://www.ahia.org/assets/Uploads/pdfUpload/WhitePapers/DefiningAuditingAndMonitoring.pdf

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Provider Monitoring

"Monitoring is an on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process."

Source: Defining the Meaning of Auditing and Monitoring & Clarifying the Appropriate Use of the Terms, by Mark P. Ruppert, CPA, CIA, CISA, CHFP. Accessed at: https://www.ahia.org/assets/Uploads/pdfUpload/WhitePapers/DefiningAuditingAndMonitoring.pdf

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Provider CAP

- Establish a formal Corrective Action Plan (CAP) (see template) for the Provider to include:
  - What the issue was
  - Who is the responsible party
  - What is going to be done to rectify it
  - By what date
  - Consequences if fail to implement
  - Validate

When:

- Multiple findings
- Dollar Threshold is "$$"

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Provider CIA

- Establish a "Compliance" Integrity Agreement with the Provider (similar to a Corporate Integrity Agreement issued by the DOJ)

When:

- Significant, multiple findings
- Dollar threshold is "$$$$"
- Termination may not be an option
- The provider is willing to work with you

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Other Provider Sanctions

- Law Enforcement
- Termination
- Legal Action
  - Civil or Criminal
- Reporting to External Agencies

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Other Provider Sanctions…

When:

- Provider is not willing to work with you.
- You have run out of other options.

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Employee Considerations

Work with Human Resources but consider…

- Confidentiality
- Experience in Investigations
- Disciplinary Actions
- Terminations, if needed

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Member Considerations

Is it the Health Plan's obligation to investigate and take corrective action against members?

- No!
- Prepare Documentation
- Distribute to State or Federal Regulatory Agencies
- Share with Commercial Insurance Policyholders

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Vendor Considerations

Who is managing vendors / FDRs?

- Contractual obligations
- Validation Processes
- Variance Reports
- Oversight at an Enterprise Level

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REPORTING

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REPORT

State Medicaid/ CMS

MEDIC

- FWA REPORTED
- ABUSE & NEGLECT REPORTED

Department of Insurance

NATIONAL PRACTITIONER DATA BASE

- PROVIDERS TERMED FOR CAUSE

MEDICAL BOARDS - DEA

- Report to appropriate Boards

PARTNERSHIPS

NHCAA National Health Care Anti-Fraud Association®

CMS.gov healthcare fraud prevention partnership

Centers for Medicare & Medicaid Services

- SIRIS database
- Healthcare Fraud Prevention Partnership (HFPP)

Health Integrity, LLC PLATO®

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PROGRAM INTEGRITY

Attendance/ attend meetings

Provide FWA oversight of delegated entities

Policies and procedures

Program Integrity Plan implementation

Submit reports required by contract

Respond to State inquiries

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Open Discussion and Questions

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