

## Health Plan of San Mateo Policy & Procedure Manual

Procedure: CP.016		Title: Investigating and Reporting Fraud, Waste, Abuse and Neglect	Original Effective Date:  05/06/2011
Revision:  8	Last Reviewed /Revised:  01/26/2021	Dept: Compliance	Page 1 of 7

Approval By: Compliance Committee		Date: 07/20/2021
Annual Review Date: 02/01/2022		
Authored by: Chief Compliance Officer		
<b>Pursuant To:</b> <input checked="" type="checkbox"/> DHCS Contract Provision Exhibit E, Attachment 2, Provision 27 <input checked="" type="checkbox"/> Health and Safety (H&S) Code 1365.5; 1347.7; 1367.04 and 1367.042 <input checked="" type="checkbox"/> CFR 42 CFR 438.608(a); 42 CFR 422.503(b)(4)(vi)(D)-(G); 42 CFR 423.504(b)(4)(vi)(D)-(G) <input checked="" type="checkbox"/> APL / DPL APLs 17-003; 15-026		<input checked="" type="checkbox"/> W & I Code 15630-15632 <input type="checkbox"/> California Title # <input type="checkbox"/> Organization Need <input checked="" type="checkbox"/> Other Medicare Managed Care Guide Chapter 21, Sections 50.4, 50.6 and 50.7; Medicare Prescription Drug Benefit Manual Chapter 9, Sections 50.4, 50.6 and 50.7; Fraud Enforcement and Recovery Act of 2009 (FERA)
Departments Impacted: All		

### Policy:

This policy documents HPSM's procedure for the prevention, detection, investigation and reporting of suspected cases of fraud, waste, abuse, or neglect.

This procedure has been developed in accordance with federal and state laws that prohibit false claims, HPSM's Code of Conduct, and the Centers for Medicare and Medicaid Services (CMS) Part C and Part D Managed Care Manuals.

### Scope

This procedure applies to (check all that apply):

<input checked="" type="checkbox"/> All LOBs/Entire Organization	<input type="checkbox"/> CCS	<input type="checkbox"/> Medi-Cal Expansion
<input type="checkbox"/> ACE	<input type="checkbox"/> HealthWorx	<input type="checkbox"/> Medi-Cal Adults
<input type="checkbox"/> CA-CMC / MMP	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Other (specify)

### Responsibility and Authority

- The Chief Compliance Officer is responsible for implementing a Compliance Program to ensure that HPSM services are provided in accordance with all applicable federal, state, and county laws and regulations.

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### Definitions

**Abuse** means any provider practices that are inconsistent with sound fiscal, business, or medical/dental practice, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to Medicare, Medi-Cal, or other HPSM lines of business.

**Deficiency** is an instance of non-compliance identified through internal audit and/or other monitoring efforts.

**FDR** means First Tier, Downstream or Related Entity. **First Tier Entity** means any party that enters into a written arrangement with HPSM to provide administrative services or health care services to HPSM members. **Downstream Entity** means any party that enters into a written arrangement with persons or entities below the level of the arrangement between HPSM and a first-tier entity. **Related Entity** means any entity related to HPSM by common ownership or control.

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Neglect** means the failure to fulfill a caretaking obligation such as assisting in personal hygiene, providing food, clothing, or shelter, protecting a person from health and safety hazards, or preventing malnutrition.

**Waste** means an overutilization or misuse of resources that results in unnecessary costs to the healthcare system, either directly or indirectly.

### Procedure

#### 1.0 Staff Responsibilities

1.1 Every HPSM employee, including regular, temporary, and contract employees and interns are trained at onboarding and annually thereafter of the requirement to report compliance issues in accordance with policy CP.003, including issues of fraud, waste, abuse or neglect.

1.1.1 Every employee has the responsibility to understand his/her job functions and associated processes in order to identify irregularities in the practices of providers, FDRs, members, or employees.

1.2 HPSM Compliance staff is required to investigate potential fraudulent or abusive actions or practices by providers, FDRs, members, or employees. Examples of practices investigated for potential fraud/abuse include:

1.2.1 Patterns of billing, such as potentially fraudulent claims, or data inconsistencies.

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- 1.2.2 Inappropriate treatment, aberrant or abusive prescribing patterns, or the withholding of medically necessary services from members.
- 1.2.3 Falsification of credentialing/recredentialing information.
- 1.2.4 Inappropriate charges to Members for covered services.
- 1.2.5 Drug seeking behavior by Members.
- 1.2.6 Prescription drug forging or altering of drugs and other acts mentioned in the Prescription Drug Benefit Manual chapter 9 (Fraud, Waste, and Abuse).
- 1.2.7 Inappropriate enrollment or disenrollment of members.
- 1.2.8 Noncompliance with quality assessment or grievance and appeals procedures.
- 1.2.9 Marketing violations, including selective marketing.
- 1.2.10 Lack of oversight or poor oversight of FDRs.

### 2.0 Fraud Detection Methods

- 2.1 HPSM uses a combination of claims editing software and weekly oversight reports and edits integrated with the claims adjudication system to monitor claims prior to payment to identify such billing errors as unbundling, double billing, and the inappropriate use of modifiers, and inappropriate billing according to Correct Coding Initiative edits.
- 2.2 Quality Site Review Nursing staff, in collaboration with the Chief Medical Officer or their designee or the Dental Director, conducts medical record audits when patterns of fraud or abuse are suspected.
- 2.3 Claims Department staff review pended claims to prevent payment for wrong or suspicious claims.
  - 2.3.1 A compliance hotline is available so that callers can report suspected instances of fraud or abuse anonymously. The toll-free hotline number, 1.844.965.1241, is displayed prominently throughout HPSM offices and on HPSM's intranet page.
  - 2.3.2 Health Services Department clinical staff reviews prior authorizations requested by providers for appropriateness of service.
  - 2.3.3 Examples of potential Member fraud and abuse can include overuse of emergency rooms, doctor shopping for prescriptions of narcotics, overuse of medications or services identified through claims review and through multiple prior authorization requests for the same or similar medications or services.
  - 2.3.4 HPSM pharmacy staff reviews prior authorization (PA) requests for selected controlled substances and other potential drugs of abuse. Reviewers may identify red flags which include unusual quantity requests, multiple prescribing providers and frequency of similar requests for the same member, and inappropriate prescribing per clinical guidelines. Pharmacy staff closely reviews and investigates any prescriptions that do

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not fall within clinical guidelines. If potential FWA cases are identified, the staff brings the cases to the attention of the medical directors and the Compliance Department.

- 2.3.5 The pharmacy staff closely reviews and investigates opioid utilization cases identified in the quarterly CMS Overutilization Monitoring System (OMS) reports.
- 2.3.6 Potential cases of neglect will be identified through Care Coordination activities.
- 2.4 Grievance and Appeals staff may identify potential fraud and abuse incidents by providers or members that require additional research or referral to the Compliance Department.
- 2.5 Provider Services credentialing staff checks national, state, and professional debarred and suspended lists to identify any provider or FDR who has been suspended, terminated or sanctioned. Excluded providers are ineligible to serve as a member of HPSM's provider network.
- 2.6 HPSM's Pharmacy Benefits Manager (PBM) reviews pharmacy billing practices through claims edits, pharmacy desk and on-site audits, and pharmacy staff credentialing. A pharmacy consultant validates the PBM's work including that pricing performance guarantees are met in accordance with the PBM's contract and reports are sent to HPSM for review. Cases of potential fraud are discussed with HPSM's Chief Compliance Officer, who is responsible for reporting such cases to CMS or DHCS.
- 2.7 Compliance Department internal auditing activities, including but not limited to the review of the CMS High Risk Pharmacy Reports and CMS Alerts.
- 2.8 HPSM creates annual Compliance and Internal Audit Work Plans, for monitoring and auditing possible noncompliance risks in each department.
- 3.0 Reporting Potential Cases of Fraud, Waste, Abuse, or Neglect
  - 3.1 HPSM's requires staff to report all compliance concerns of which they are aware pursuant to policy CP.003.
    - 3.1.1 The Chief Compliance Officer must update all staff of any changes to his or her office location or contact information.
    - 3.1.2 If HPSM appoints a new Chief Compliance Officer, the name, office location, and contact information of the new Chief Compliance Officer must be widely communicated to all staff.
  - 3.2 A dedicated hotline has been set up to report incidents of potential fraud or abuse. All messages left on the hotline will be investigated.
  - 3.3 Any employee who makes a report in good faith is not subject to retaliation, intimidation or any other form of reprisal per policy CP.005.
    - 3.3.1 If the identity of a reporting employee is known, HPSM makes every effort to maintain the confidentiality of their identity within the limits of the law. HPSM also makes every effort to protect the rights of any employee accused of engaging in fraud or abuse.

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- 3.3.2 Any employee who deliberately makes a false accusation with the intention of retaliating or harming an employee, member, or provider is subject to disciplinary action up to, and including, termination.
- 3.4 HPSM may discharge any employee, terminate the contract of any provider or recommend the withdrawal of a member from a program who, upon investigation and referral to the appropriate oversight agency, has been identified as involved in fraudulent or abusive activities.
- 3.5 Staff members who resign or are dismissed are asked to complete an exit questionnaire which includes a question regarding their knowledge of any conduct or activity that could be considered questionable, unethical, or illegal.
  - 3.5.1 The employee is provided an opportunity to identify whom, if anyone, was notified of his or her concerns and to report issues or concerns that were noted but not adequately addressed.
- 3.6 Suspected cases of neglect must be reported as defined by state law (California Welfare and Institutions Code 15630).
  - 3.6.1 Reporting depends upon the location of an incident, e.g., long term care facility, state mental hospital, state developmental center, or other location.
  - 3.6.2 Reporting depends upon the severity of the incident.
  - 3.6.3 Location and severity determines where reports are sent which can include, for example, law enforcement, local ombudsman for long-term care, state agencies, or adult protective services agency.
- 4.0 DHCS Notification of a Credible Allegation of Fraud
  - 4.1 Upon notice from DHCS, the designated Compliance staff will process a credible allegation of fraud pursuant to CP-DP.005.
  - 4.2 In the instance that any HPSM staff is notified of a credible allegation of fraud from DHCS, that notification must be forwarded to the Compliance Department immediately upon receipt.
- 5.0 Internal Investigations
  - 5.1 All potential cases of fraud or abuse reported to the Compliance Department are investigated.
    - 5.1.1 Under the direction of the Chief Compliance Officer, Compliance Department staff gathers information regarding the case.
    - 5.1.2 Investigations for all cases begin as quickly as possible, but no later than 10 business days after the date the potential noncompliance or FWA is identified or reported. Internal audits may be conducted and patterns of provider billing reviewed.
      - 5.1.2.1 If the investigation shows recurring patterns or trends the case may be reported as a deficiency per CP.027 corrective action process.

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- 5.1.3 If the case involves prescription drugs, the Compliance Department works with the Pharmacy Director or their designee and with HPSM's Pharmacy Benefits Manager.
- 5.1.4 If potential member fraud or abuse is detected, the Customer Support Director or designee assists in the investigation and gathers information as appropriate.
- 5.1.5 The Chief Medical Officer or their designee or the Dental Director may assist in investigations involving clinical decisions.
- 5.2 At a minimum, all cases are submitted to the Compliance Committee. Substantiated cases may be reviewed at a Committee meeting.
  - 5.2.1 If needed, a separate ad hoc work group may be established to address a specific FWA issue.
  - 5.2.2 Follow up may include a targeted audit of provider claims and review of medical/dental records.
  - 5.2.3 If appropriate, a hold may be placed on processing of relevant claims while an investigation is going on.
  - 5.2.4 If billing errors or abusive billing practices are identified, a Corrective Action Plan must be implemented. If fraud is suspected, reports are made to the appropriate regulatory agencies and/or law enforcement.
  - 5.2.5 The Chief Compliance Officer reports all potential cases of fraud to the Chief Executive Officer.
- 5.3 Substantiated cases are reported to the San Mateo Health Commission in accordance with policy CP.009.
- 6.0 Recovery of Identified Abusive or Fraudulent Payments
  - 6.1 Compliance Staff works with the HPSM Claims and Finance departments to pursue recoveries of any amounts paid that relate to identified fraud and abuse activities pursuant to Claims Policy CL.07-04.
- 7.0 Self-Reporting to Oversight Agencies
  - 7.1 HPSM reports potential FWA to regulatory agencies in accordance with the timeframes specified in Compliance Department Policy CP-DP.002.
  - 7.2 The Chief Compliance Officer reports fraudulent and abusive practices to the appropriate oversight agencies using standard reporting processes. These agencies include CMS, DMHC, DHCS, the California Office of the Attorney General, OIG HHS, MEDIC, and various federal, state, and local law enforcement agencies.
  - 7.3 The Chief Compliance Officer, in consultation with the Compliance Committee or the CEO when appropriate, is responsible for managing any communication with the oversight agency or agencies to which the self-report is made.

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### 8.0 Confidentiality and Record Retention

- 8.1 All reports and records generated during the investigation are retained according to HPSM policy CP.019.
- 8.2 Upon request by a federal or State oversight agency, the records pertaining to an investigation are made available to the requesting agency.
  - 8.2.1 The Chief Compliance Officer and/or CEO shall consult County Counsel if the investigation could be the subject of a court case or administrative appeal hearings.

### Related Documentation

- CP.003 Reporting Compliance Issues
- CP.005 Non-Retaliation & Non-Intimidation
- CP.006 False Claims Act Compliance
- CP.009 Notification Process for Compliance Issues
- CP.019 Records Retention
- CP.026 Code of Conduct
- CP.027 Corrective Action Plan (CAP) Monitoring Process CP-DP.002 FWA Investigation and Reporting
- CP-DP.014 CAP Process
- CL.07-04 Claims Retractions – Processing, Reporting and Recovering Overpayments

### Attachments

- None

Log of Revisions	
Revision Number	Revision Date
0	05/06/2011
1	06/01/2012
2	08/30/2013
3	06/15/2014
4	08/19/2015
5	02/22/2017
6	01/16/2018
7	12/17/2019
8	01/26/2021