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| <b>HEALTH PLAN OF SAN JOAQUIN</b>         |                                |  |                         |
| <b>Subject: Fraud and Abuse Reporting</b> |                                |  |                         |
| <b>Department:</b> Compliance             |                                |  | <b>Policy #:</b> CMP 05 |
| <b>Applies to:</b> All HPSJ Staff         |                                |  | <b>Scope:</b>           |
| <b>Effective Date:</b><br>1/1/99          | <b>Revised Date:</b><br>9/1/04 | <b>Approved by:</b><br><br><i>Signature on file</i><br>(Title of Sr. Exec.responsible) |                         |

**POLICY**

- A. The Health Plan of San Joaquin (HPSJ) shall make a reasonable effort to detect and prevent fraud and abuse in an effort to reduce costs to the Plan, providers, members, and others adversely affected by such activities.
- B. HPSJ shall strive to protect its members by investigating and reporting suspected fraud and abuse, and taking appropriate corrective action.

**DEFINITIONS**

- A. “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Plan, 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 the Plan.
- B. “Fraud” means the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
- C. “Preliminary investigation” means an investigation used to determine whether there is sufficient evidence of fraud or abuse reported from any source or questionable practices identified by HPSJ. Preliminary investigations are conducted by the Quality Improvement (QI) Nurse – responsible for fraud investigation (QI Nurse) in accordance with QA 27.
- D. “Full investigation” means that based upon the findings of the preliminary investigation that HPSJ was required to report the case to the Department of Health Services or law enforcement.

## **PROCEDURE**

### **A. Training & Education**

1. Employees – The Claims Manager shall conduct training not less than annually for the Claims and Utilization Management departments, and other departments if applicable.
2. Providers – The Fraud & Abuse Committee shall determine the manner in which providers are informed about how to detect health care fraud including, but not limited to, the provider manual and/or newsletter.
3. Members – The Fraud & Abuse Committee shall determine the manner in which members are informed about how to detect health care fraud including, but not limited to, the member newsletter and web site.

### **B. Identification of fraud or abuse**

1. Oral or Written notification by a provider or a member
  - Utilization Management, Claims, Provider Services, and Member Services staff promptly shall refer the case to a QI Nurse by documenting using the claims system with the Event Code SFAA, or by forwarding information with supporting documentation.
  - The QI Nurse shall conduct initial review and research of a case to determine whether an investigation is warranted and shall proceed in accordance with QA 27.
2. Claims and Pre-authorization requests
  - It is expected that Claims and Utilization Management staff shall report, at a minimum, the following instances to the QI Nurse:
    - CPT code on claim does not match Authorization
    - Over-utilization of claim codes or inappropriate use of claim codes per claim guidelines
  - Claims staff shall report billing irregularities to Provider Services at the discretion of the Claims Manager. If Provider Services determines that further investigation is warranted they shall follow the procedures set forth in 4.2.1
3. Credentialing Specialist will search federal and state web sites including but not limited to the HHS Office of Inspector General, National Practitioner Data Bank, California Board of Medicine and PrimeSource Web for any physician who has been suspended or excluded from participating in Medicare or Medicaid programs. This search will be conducted during the initial credentialing process and thereafter as part of each recredentialing. A provider found to be under mandatory or permissive sanction due to health care fraud or abuse will be denied admission into the HPSJ network.

## C. Reporting

1. The QI Nurse shall report to the Compliance Officer within ten (10) working days and upon approval by the QI Manager all cases of suspected provider and member fraud and abuse that result in a preliminary investigation.
2. Department of Health Services – The Compliance Officer shall report to the Contract Manager within ten (10) state working days all cases of suspected provider and member fraud and abuse involving the Medi-Cal program that result in a preliminary investigation via confidential fax.
  - At the conclusion of any fraud or abuse case investigation, the QI Nurse will submit to the DHS Program Integrity Unit a summary of the investigation using the Confidential Medi-Cal Complaint Form (Form 609), with a copy to the Compliance Officer.
  - Compliance Officer will provide the Contract Manager with a copy of the Form 609 within ten (10) state working days of receiving it from the QI Nurse, via confidential fax..
3. Department of Managed Health Care – The Compliance Officer shall report annually on HPSJ efforts to deter, detect and investigate fraud. The report shall include information about those complaints that necessitated investigation by the Department of Health Services or law enforcement, specifically:
  - Number of complaints that warranted preliminary investigation
  - Cases that warranted full investigation to include:
    - The provider’s name and number
    - The member’s name and ID number
    - The source of the complaint
    - The type of provider
    - The nature of the complaint
    - The approximate range of dollars involved, if relevant; and
    - For cases referred to law enforcement, the legal and administrative disposition of the case

## D. Conflicts of Interest or Retribution

1. HPSJ maintains an Ethical Conduct policy that prohibits retribution against an employee, provider or member for filing a complaint of any kind. The Fraud & Abuse Committee chair shall dismiss from participating in a full investigation any employee with a conflict of interest.

**REFERENCE**

- A.** Health and Safety Code, Section 1348 – Antifraud plan
- B.** DHS Contract, Attachment 2, Exhibit E, Provision 26 - Reporting
- C.** 42 CFR Part 455§§§14, 15 & 17 – Investigations and Reporting
- D.** Welfare and Institutions (W&I) Code, Section 14043.1 – Definitions
- E.** W&I Code, Section 14124.2 – Authority to Conduct Audits
- F.** W&I Code, Section 14026 - Misuse of Medi-Cal card
- G.** W&I Code, Section 14107 & 14107.1 – Filing a false Medi-Cal claim
- H.** California Code of Regulations (CCR), Title 22, Section 51470 – Billing for services provided
- I.** CCR, Title 22, Section 51472 – Sub-standard services
- J.** CCR, Title 22, Section 51473 & 51473.1 – Excessive services
- K.** QA 27 – Potential Quality Issues Report
- L.** CMP 03 – Ethical Conduct
- M.** CMP 07 – Federal & State False Claims Act

| Created by/Date       | Revised by/Date    | Revised by/Date | Revised by/Date | Revised by/Date | Revised by/Date |
|-----------------------|--------------------|-----------------|-----------------|-----------------|-----------------|
| D. Goodman<br>5/19/04 | N. Raymond<br>8/05 |                 |                 |                 |                 |

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| <b>HEALTH PLAN OF SAN JOAQUIN</b>                    |                                |  |                         |
| <b>Subject: Fraud and Abuse Protection Committee</b> |                                |  |                         |
| <b>Department:</b> Compliance                        |                                |  | <b>Policy #: CMP 06</b> |
| <b>Applies to:</b> All HPSJ Staff                    |                                |  | <b>Scope:</b>           |
| <b>Effective Date:</b><br>9/1/04                     | <b>Revised Date:</b><br>1/1/07 | <b>Approved by:</b><br><br><i>Signature on file</i><br>Chief Executive Officer |                         |

**POLICY**

The Health Plan of San Joaquin (HPSJ) maintains a Fraud and Abuse Protection Committee comprised of officers of the company, management personnel and representatives from the Quality Improvement Department. The Committee will meet semi-annually to review the progress of preliminary and full investigations and make recommendations. The Committee will also determine the manner in which providers and members are informed about how to prevent and detect health care fraud.

**DEFINITIONS**

- A. “Abuse” means provider practices that are inconsistent with sound fiscal business, or medical practices, and result in an unnecessary cost to the Plan, 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 the Plan.
- B. “Fraud” means the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
- C. “Preliminary investigation” means an investigation used to determine whether there is sufficient evidence of fraud or abuse reported from any source or questionable practices identified by HPSJ.
- D. “Full investigation” means that based upon the findings of the preliminary investigation that HPSJ was required to report the case to the Department of Health Services or law enforcement.

## **PROCEDURE**

- A. The Fraud and Abuse Protection Committee may be comprised of the following HPSJ personnel:
1. Compliance Officer
  2. Medical Director
  3. Pharmacist
  4. Director of Medical Management
  5. Quality Improvement Manager
  6. Quality Improvement Nurse responsible for fraud investigation
  7. Claims Management
  8. Other employees of HPSJ may participate in discussions, meetings, hearings, etc. regarding a physician or member only in circumstances where the employee has information relevant to the case. The Committee will not disclose provider or member information outside of the Committee except as permitted by law or regulation, or when it is appropriate to enforce corrective action or sanctions.
- B. Training & Education
1. Providers – Prepare materials intended to inform providers how to detect and report health care fraud including, but not limited to, the provider manual and/or newsletter.
  2. Members – Prepare materials intended to inform members about how to detect and report health care fraud including, but not limited to, the member newsletter and web site.
- C. Investigations of fraud and abuse
1. The Quality Improvement (QI) Nurse responsible for fraud investigation is the lead investigator of reported fraud and abuse.
- D. Fraud and Abuse Logs
1. The QI Nurse will maintain a log of preliminary and full investigations in the J:/drive under Fraud & Abuse Logs.
  2. Committee members who are also participating in an investigation must document calls with providers and regulators in the appropriate log.
  3. Committee members are encouraged to review the logs frequently for updates.
- E. Meetings

1. The Committee shall convene not less than bi-annually for the following reasons:
2. To review active preliminary and full investigations and make recommendations for remediation.
3. The QI Nurse will be responsible for reporting to the QIUM Committee recommendations pertaining to a provider.
4. The Compliance Officer will be responsible for reporting to the State recommendations for disenrollment of a member.
5. To review all new and modified policies developed by HPSJ in its effort to prevent, detect and mitigate the effects of fraud and abuse.

**REFERENCE**

- A. CMP 05 – Fraud and Abuse Reporting
- B. CMP 07 – Federal & State False Claims Act
- C. QA 27 – Quality Investigations

| Created by/Date       | Revised by/Date      | Revised by/Date    | Revised by/Date | Revised by/Date | Revised by/Date |
|-----------------------|----------------------|--------------------|-----------------|-----------------|-----------------|
| D. Goodman<br>6/10/04 | N. Raymond<br>8/1/05 | N. Raymond<br>1/07 |                 |                 |                 |