

Corporate Compliance-Fraud and Abuse

PROCEDURE PURPOSE AND STATEMENT OF INTENT

Midwest Health Plan, Inc. (MHP) is committed to conducting its affairs in accordance with all applicable Federal and State laws, regulations, licensing and contract obligations. In addition, MHP participates for accreditation with the National Committee for Quality Assurance (NCQA) and its accompanying audit and reporting requirements for the Healthplan and Employer Data and Information Sets (HEDIS). MHP is therefore obligated to provide monthly, quarterly, annual and special reports, information and analysis on a timely basis and in specified formats. All of these activities are to be conducted in an accurate, ethical and legal manner.

MHP has developed a Compliance Program to assure that these activities are carried out in a timely and accurate manner.

Also, MHP strives to maintain the Compliance Program to prevent and detect violations of the law by any of its providers or contractors and exercises due diligence in seeking to prevent and detect abuse, fraudulent or criminal acts by its employees or agents.

MHP monitors all of its business operations for the purpose of reporting fraud or abuse to federal and state government agencies and officials.

- Definitions:

Fraud is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

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

Reporting can be done anonymously. Reporting suspected fraud and abuse can be done by calling or sending a letter/memo to:

Midwest Health Plan
Compliance Officer
5050 Schaefer Road
Dearborn, MI 48126
Toll free #866-622-8980

Reporting suspected fraud and abuse and complaints of fraud and abuse that warrant preliminary investigation can be done by submitting them on line at www.michigan.gov/mdch/inside/community_health/fraud_and_abuse/ or by calling or sending a letter/memo to:

To MDCH:
Program Investigation Section
Capital Commons Center Building
400 South Pine, 6th Floor
Lansing, Michigan 48909,
Program Investigation Section
Toll Free: 1-866-428-0005

PROCEDURE STATEMENT

A. Monitoring and Reporting Fraud and Abuse

- Every department within MHP is required to monitor fraud and abuse.
- In the event any department within the organization discovers or suspects a health care provider, member, or employee fraud or abuse, the department is required to submit its findings to the Compliance/Privacy Official for evaluation.
 - If the activity as suspected by the referring department qualifies under the definition of fraud or abuse, then the Compliance/Privacy Official shall oversee the investigation, and recommend referral of the matter to the appropriate governmental agency including but not limited to the State of Michigan’s Program Investigation Section and the Office of Inspector General (OIG).

B. Detecting Fraud and Abuse by Providers and Members

- Any department responsible for any of the following shall report a suspicion of fraud or abuse to the Compliance/Privacy Official for investigation:
 1. Processing or reviewing medical or pharmacy claims;
 2. Provider profiling reports;
 3. Approvals or denials of health services to members;
 4. Complaints or grievances filed by members;
 5. Member customer service inquiries;
 6. Medical record reviews;
 7. Credentialing; or
 8. Utilization.
- Provider Fraud and Abuse includes, but is not limited to:
 1. Falsification of provider credentials;
 2. Billing for services not provided;
 3. Double billing, upcoding, and unbundling;
 4. Collusion (providers agree on minimum fees they will charge and accept); and
 5. Under utilization (not ordering medically necessary covered services).
- Member fraud or misrepresentation includes, but is not limited to:
 1. Altering a prescription;
 2. Altering other medical records;
 3. Altering referral forms;
 4. Allowing another individual use of a Medicaid or MHP card for the purpose of obtaining medical benefits; and
 5. Using transportation services for purposes other than what is considered a covered non-emergent transportation benefit.

MHP Departments identify potential member and provider fraud and abuse through the following:

1. Medical Auditing/Quality Improvement
 - Routine Audits; or
 - Complaints by providers, members and employees
2. Claims Department
 - Processing and adjudicating all claims submitted by providers. Built into the claims processing system are various edits to help prevent claims from being inappropriately reimbursed. Types of edits include, but are not limited to, those relating to member eligibility, coordination of benefits, duplicate claims and referral or other authorization requirements. Code Review software is being implemented to assist in proper processing of claims payment.
 - If a particular provider appears to have a pattern of inappropriate billings, an audit of past billings may be conducted by the Quality Improvement Department.

- Complaints by providers, members and employees
3. Quality Improvement
 - MHP's Credentialing Department is responsible for credentialing and recredentialing activities, which include periodic verification of necessary licenses, board certification and participation status in the Medicare and/or Medicaid programs according to the Credentialing Program and policies and procedures. Verification of these items helps to lessen the risk that members receive health care services from unqualified individuals, or payment is made to unqualified providers.
 - MHP Quality Department maintains a process to document, track and investigate possible quality of care or quality of service concerns. Issues related to potential quality of care or service, over/under utilization, fraud and abuse discovered during the review of reported concerns or during any medical record documentation review or upon review of potential quality issues forwarded for review (Policy 6.08 Procedure for investigating Potential Quality of Care Issues)
 - Complaints by providers, members and employees.
 - Review of Customer Service monthly complaint log for issues relating to underutilization of services, refusal to refer, and potential fraud and abuse.
 - Review of medical record audits for referral patterns and quality of care
 - HEDIS annual reports with provider profiling and comparison to national standards
 4. Customer Service
 - Inquiry and Complaint Identification Procedure (Formal Member Grievance Policy (4.01))
 - The member may indicate that they have been involved in some type of fraudulent behavior.
 - Health care providers may notify Customer Service of a member's fraudulent behavior or misrepresentation, usually when a member is discharged from a provider's care.
 - Transportation services may notify Customer Service of a member's abuse of the transportation services.
 - Members informing Customer Service of balance billing. Balance billing members for services covered by Midwest Health Plan is prohibited
 - Other complaints by providers, members and employees.
 - Review of complaint logs and customer call logs. All calls to Customer service are recorded in the MC400 system. Each call is coded according to the reason for the call. A summary report is reviewed by the Director of Customer Service. All potential quality issues are forwarded to the QI Department for review and investigation, all other calls are forwarded in a summary report to QI for review.
 5. Medicaid Liaison
 - Monitoring of MHP compliance with Medicaid requirements;
 6. Provider Services Department
 - Face to face, monthly visits to high volume PCPs (over 100 members) are conducted. At these meetings, the provider services representative discusses any issues or concerns. The providers are informed of our Corporate Compliance policy via our PCP Administrative Manual, our web site, our quarterly meetings, and through our newsletters.
A provider/practitioner may refuse to treat a member because of fraudulent behavior or misrepresentation
 - Provider Services Representatives encourages providers and office staff to identify and notify MHP of any suspected fraudulent behavior during orientation and during the monthly visits to their offices.
 - Provider Services Representatives review provider profiling reports with providers/practitioners
 - Complaints by providers, members, and employees
7. Utilization Management

- An initial authorization request;
- Under and Over Utilization according
 - Medical Necessity Determination
 - Reviewing Emergency Room Utilization reports
 - Through communication with members and providers during case management.
 - Other complaints by providers, members and employees.

8. Pharmacy Department (Health Services)

- Members:
 - a. This review includes, but is not limited to prescription claims reviewed
 - b. Members identified that have multiple pain medication and potential duplicate pain medication.
 - c. Provider (pharmacy or physician) complaints on controlled prescription habits.
 - d. Utilization Management reports ~Notification of Members' Frequent Emergency Room Use Procedure".
 - e. Complaints and inquiries from ancillary departments at MHP related to threatening and/or abusive behavior displayed by the member related to controlled substance prescription utilization.
 - f. Pharmacy claims data with specific queries to target specific subjects or medications.
 - Members identified as high utilizers of controlled substances:
 - a. Are restricted to the member's primary care provider (PCP) for all narcotic prescriptions
 - b. Only controlled substance prescriptions written by the PCP that are identified by their Drug Enforcement Agency (DEA) number will be able to be filled at the member's pharmacy.
 - c. A certified letter confirming the restriction of the member to the PCP Of controlled substances is sent to the member describing the potential fraudulent behavior being exhibited by the member
- Pharmacies, Providers and Practitioners:
 - a. Identifiers and Control Mechanism:
 - This review includes, but is not limited to prescription claims
 - Providers may request to be on an open or closed panel to assist in monitoring drug usage

C. Detecting Fraud and Abuse by Employees:

Employee Fraud and Abuse includes but is not limited to:

1. Falsification of provider credentials or provider network—forged signatures, pre or post date)
 2. Fraudulent contractor or subcontractor (intentionally submits false claims)
 3. Bid Rigging (collusion between state employees and HMO employees);
 4. Self dealing (contract awarded based solely on friend or family relationship);
 5. Misuse of MHP employer reimbursement programs; or
 6. Misuse of MHP equipment to obtain funds(Setting up a false provider file, billing, and receiving payment for false claims).
- Suspected fraud and abuse is identified through, but not limited to the following:
 1. MHP departmental fraud and abuse detection procedures~
 2. MHP reimbursement programs;
 3. Direct member reimbursement and billing address audits;
 4. Suspicious behavior; and
 5. Employee, provider and member complaints.

D. Reporting Fraud or Abuse

- MHP will fully cooperate with DCH in the detection, investigation, reporting and follow up on all issues.

MHP must report all suspected fraud and/or abuse and complaints of fraud and abuse that warrant preliminary investigation to the DCH, Program Investigation Section. This can be done by submitting them on line at www.michigan.gov/mdch/inside_community_health/fraud_and_abuse/ or by calling 1-866-428-005 or sending a letter/memo to:

Program Investigation Section
 Capital Commons Center Building
 400 South Pine, 6th Floor
 Lansing, Michigan 48909,

When reporting suspected fraud and/or abuse, MHP will provide DCH the following information:

- Nature of the Complaint
- The name of the provider, individuals and/or entity, including their address, phone number, and Medicaid identification number, and any other identifying information.
- Source of the complaint
- Type of provider
- Approximate range of dollars involved
- Legal and administrative disposition of case, including actions taken by law enforcement officials to whom the case has been referred.
- Any other information deemed necessary or requested by MDCH

Reporting may be done anonymously.

MHP shall provide the number of complaints that warrant preliminary investigation each year-as requested by DCH. MHP shall inform DCH of actions taken to investigate or resolve the reported suspicion, knowledge or action. MHP will cooperate fully in any investigation by the DCH or Office of Attorney General and any subsequent legal action that may result from such investigation. MHP is permitted to disclose protected health information to DCH or Attorney General without first obtaining authorization from the enrollee to disclose such information. DCH and the Attorney General shall ensure that such disclosures meet the requirements for disclosures made as part of MHP's treatment, payment, or health care operations as defined in 45CFR 164.501.

2. If needed, reporting may also be done to
 Office of Inspector General (OIG) of Health and Human Services
 Attention:HOTLINE
 330 Independence Avenue, SW
 Washington, DC 20201

E. Disciplinary actions for infractions:

Non compliant behavior is subject to the same disciplinary action steps as implemented by Human Resources (HR). These may include:

For Employees: All steps are documented in the CAP and kept in the employee's file in HR.

- First step: verbal warning
- Second step: written warning
- Third step: suspension (number of days determined by HR)

- Termination

For Members: All interactions with members are documented in the Customer Services computer system. Depending upon the issue the following steps may occur:

- Pharmacy lock in (PCP must approve all prescriptions written for member)
- Change PCPs (when this occurs, the new PCP is informed of the potential case of fraud or abuse conducted by member)
- Take necessary steps to dis-enroll member

For Providers: All interactions are documented in the Quality Improvement Department's individual provider file. All steps are documented in the CAP—if one is developed with the Provider. The following steps may occur:

- Closing Provider's practice to new members
- Transferring current members to new PCP
- Terminating provider
- Reporting Provider to NCDB (databank)

Deficit Reduction/False Claims

General Purpose:

Pursuant to certain provisions of the Deficit and Reduction Act of 2005, the purpose of this policy is to provide employees and contractors with educational information concerning false claims and similar laws. As set forth in Midwest Health Plan's Compliance Program, each employee is responsible for following the company's policies and procedures including using good faith efforts to comply with applicable laws and conducting business in an ethical and legal manner. Employees are also responsible for identifying and reporting fraud and abuse as set forth in the compliance policies and procedures. These policies and procedures have been provided to employees in the past and are also available in the Compliance Officer's office and on the company's shared drive.

Information Regarding False Claims:

The submission of false claims is prohibited by several different statutes. In general, a violation of the false claims laws includes submitting or causing to be submitted a claim for payment to the federal or state government (or using a false record to get the claim approved) when the claim is false or fraudulent.

The Federal civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the federal or state government, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the federal or state government by having a false or fraudulent claim allowed or paid. Violation of the False Claims Act may result in substantial civil monetary penalties of up to \$11,000 per false claim, three times the damages sustained by the government and exclusion from the Medicare and Medicaid programs.

Under the Federal Civil False Claims Act, to knowingly present a false claim means that a person (1) has actual knowledge that the information on the claim is false (2) acts in deliberate ignorance of the truth or falsity of the information on the claim; or (3) acts in reckless disregard of the truth or falsity of the information on the claim. The deliberate intent to defraud is not required in order to be found in violation of the Act.

The Federal Civil False Claims Act also contains provisions allowing individuals to bring suit on behalf of the government. As detailed below, this law also contains employment protections for those individuals who assist in false claims cases. For example, in general, the law does not permit employers to take retaliatory actions against employees who file such cases.

There are also criminal laws prohibiting false claims, which prohibit knowingly and willingly making or causing to be made any false statement or representation or material fact in any claim or application for benefits under Medicare or Medicaid. Violations are felonies and are punishable by imprisonment and/or fines.

The Medicare/Medicaid Civil Monetary Penalties law prohibits submission of claims to Medicare or Medicaid that a provider knows or should know are false or fraudulent and provides for the imposition of sizable penalties.

The Health Insurance Portability and Accountability Act of 1996 amended the Federal penal code to criminalize federal health care offenses. These offenses include, for example, health care fraud that covers fraud against any public or private health care benefit program or obtaining money by false pretenses in connection with the delivery or payment of healthcare benefits. The offenses also include false statements relating to matters concerning any public or private healthcare benefit program. These offenses are punishable by fine or imprisonment, or both.

Other federal criminal laws may be used to prosecute the submission of false claims, including prohibitions on making false statements to the government and engaging in mail fraud. Felony convictions will result in exclusion from Medicare and Medicaid and other federal programs for a minimum of five years.

The State of Michigan also has a law (known as the Michigan Medicaid False Claims Act) prohibiting fraud in obtaining payments in connection with the Medicaid program. This law is similar to the Federal False Claims Act including containing provisions allowing individuals to bring suit on behalf of the government. It also protects employees who initiate, assist or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law.

Non-Retaliation (Whistle Blower):

As discussed in more detail in the Compliance Program and the policies, employees are responsible for internally reporting compliance issues including issues that raise false claims concerns. It is the policy of the company that no employee who makes a report of alleged wrongdoing will be subjected to reprisal, harassment, retribution, discipline or discrimination by company or any of its employees or agents based on having made the report. Any employee or agent who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by the company. The Michigan Whistleblowers' Protection Act also provides protection to employees who report a violation or suspected violation of state, local or federal law. The Michigan Medicaid False Claims Act also provides protection for employees who initiate, assist or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law. The Federal False Claims Act also contains protections for employees, who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

PROCEDURE STATEMENT:

A. Compliance Standards and Manuals.

- Compliance standards shall be developed and kept current with applicable laws and regulations. This includes the False Claims Act and other provisions named in section 1902(a)(68)(A).
- A compliance manual shall be updated annually and used as a resource for staff to enhance the ability to perform their responsibilities in compliance with applicable laws and regulations. This manual includes all policies and procedures related to the detection and prevention of waste, fraud and abuse.

B. Employee Participation and Reporting

- It is the responsibility of every employee in the organization to abide by applicable laws and regulations and support MHP's compliance efforts.
- All employees are required to report their good faith belief of any violation of any applicable law to the Compliance Official. MHP, or at the request of the employee, will provide such anonymity to the employee(s) who report the violation as is possible under the circumstances in the judgment of MHP, consistent with its obligations to investigate employee concerns and take necessary corrective action. There shall be no retaliation in the terms and conditions of employment as a result of such reporting.
- Employees are expected to report their good faith belief or violations of the Compliance Program or applicable laws
 - (a) either orally or in writing to their manager;
 - (b) or either orally or in writing to the Compliance Official, 5050 Schaefer Road, Dearborn, MI 48126. Toll free number of #866-622-8980.
 - (c) or reporting can also be made directly to the Department of Community Health Program Investigation Section at 1-866-428-0005 or by writing Department of Community Health, Program Investigation Section, 400 S. Pine Street, Lansing, Michigan 48909, and the Office of Inspector General at 1-800-447-8477, or write to Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue, SW, Washington, DC 20201.

C. Responsible Official

- MHP has designated the Compliance Official as the individual within MHP responsible for the overall implementation and operation of the Compliance Program.

Source: Section 6032 of the Deficit Reduction Act of 2005
42 USC Section 1396a(a)68)