Fraud, Waste & Abuse

Detection Manual

Developed for use by all Senior Network Health, LLC Directors, Officers, Managers and Staff.

Developed 03/2023; DOH Plan Manager Approval 3/30/2023

SNH042

Table of Contents

WAYS TO REPORT SUSPECTED FRAUD, WASTE AND ABUSE

- **Notify your Supervisor or a Director**
- **Call the MVHS Compliance Officer: 315-624-5146**
- **Call EthicsPoint: 1-800-954-9418**
- **Visit: mvhealthsystem.ethicspoint.com**
- **Or write to:**

Mohawk Valley Health System

Attn: Compliance Officer

1656 Champlin Ave

Utica, NY 13502

INTRODUCTION

Fraud, Waste and Abuse (FWA) is a significant concern for Senior Network Health, LLC (SNH) and the entire health insurance industry, including Medicaid Managed Care programs.

The Centers for Medicare & Medicaid Services (CMS), the FBI, and National Health Care Anti-Fraud Association (NHCAA) all estimate that tens of billions of dollars are lost to health care fraud every year.

The New York State Office of the Medicaid Inspector General (OMIG) reported that in 2018 it recovered nearly $2.7 billion in Medicaid recoveries and cost savings. As of May 31, 2019, the Medicare Fraud Strike Force recovered $3.48 billion because of 2,829 criminal indictments.

As the costs of health care rise, FWA prevention and detection is critical to ensuring continued coverage for New Yorkers who rely on Medicare and Medicaid—3.5 million and 6.4 million members, respectively, as of August 2019.

This Fraud, Waste and Abuse Detection Manual outlines how everyone at SNH can do their part to address FWA, and describes the robust systems SNH has in place, and in implementation, to detect, prevent, and investigate FWA.

I. FRAUD, WASTE AND ABUSE – OVERVIEW

1. What is Fraud Waste and Abuse?

Fraud is an intentional deception, concealment or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.

Waste is the overutilization of services, or other practices that directly or indirectly, result in unnecessary cost to the Medicaid program. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.

Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.

Together, Fraud, Waste and Abuse are often referred to as **FWA.**

Examples of FWA include:

By Providers:

- Billing for services not provided;
- Deliberately filing incorrect diagnoses;
- Upcoding procedures to more complex services;
- Propagating or failing to address quality of care issues;
- Failure to maintain adequate medical records;
- Unbundling services to increase revenue when a more appropriate code exists;
- Misrepresenting services or dates of service;
- Billing non-covered services as covered services;
- Ineligible or excluded providers rendering services and billing under an eligible provider's identifier;
- Providing and billing for unnecessary testing and services;
- Making "cluster visits" (i.e., multiple visits within a short time);
- An absence of routine care services;
- Billing for more time (e.g., anesthesia, psychotherapy) than provided;
- Duplicate billing of more than one insurer for the same patient;
- Not crediting durable medical equipment (DME), supplies and prescription drugs back to the insurer when the original was not picked up;
- Re-selling DME, supplies or prescription drugs when the items were not received by the patient and the insurer was not credited;
- Diverting drugs from medically necessary use to illegal resale; or
- Accepting or offering kickbacks and bribery.

By Members:

- Loaning a SNH identification card for use by another person;
- Altering the amount or date of service on a claim form or prescription receipt;
- Fabricating claims;
- Reselling items provided by the plan;
- "Doctor shopping" (seeing several providers to obtain frequent drug prescriptions); or

- Making excessive trips to the emergency room for narcotics.

By Non-Members:

- Using a stolen SNH card to obtain medical services or prescriptions; or
- Engaging in impermissible sales and marketing practices to steer potential members to or from the SNH plan.

By SNH Employees:

- Creating claims;
- Delaying assignment of a provider to reduce costs;
- Failing to provide covered services to reduce costs;
- Engaging in impermissible sales and marketing practices, such as using unapproved promotional materials, falsifying eligibility information, enrolling individuals without their knowledge or offering inducements to members and providers to join; or
- Changing member or provider addresses to intercept payments.

II. REPORTING FRAUD, WASTE AND ABUSE (FWA)

If any SNH director, officer, manager or staff member, or any other person affiliated with SNH, suspects FWA, that person is required to report the suspected FWA. As an affiliate of the Mohawk Valley Health System (MVHS), SNH employees must follow all MVHS policies pertaining to FWA and compliance. A report of suspected FWA may be made directly to a supervisor or a Director, or via:

- Compliance Officer: 315-624-5146
- **EthicsPoint**: 1-800-954-9418
- **EthicsPoint Web Portal**: www. mvhealthsystem.ethicspoint.com
- **Mail:** Senior Network Health, Attention: Compliance Officer, 1650 Champlin Avenue, Utica, NY 13502

Anyone who reports FWA may do so anonymously. All information received or discovered will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., federal and state authorities, the MVHS Legal Department, Directors and/or Senior Management).

MVHS and SNH have a strict policy of not retaliating against, or intimidating, anyone who in good faith reports suspected FWA or another compliance issue.

FWA referrals are received by the Compliance Officer through the reporting mechanisms described above, as well as other mechanisms including, but not limited to, verbal or written notification by:

- MVHS and SNH directors, officers, managers or other staff members;
- Providers, vendors, consultants, members, caregivers, or First-tier, Downstream and Related Entities (FDRs);
- Members of the public;
- Law enforcement or regulatory agencies;
- Google or other electronic news alerts;
- FWA identified during the investigation of a grievance, complaint, or appeal;
- FWA identified during the investigation of a quality of care concern;
- FWA identified during the investigation of a provider complaint; or
- FWA identified during the authorization of services or monitoring of utilization by members.

III.APPLICABLE LAWS, STATUTES AND RESOURCES SUMMARY

Federal:

- The **False Claims Act (FCA)**, 31 U.S.C. § 3729–33, as amended, provides for civil actions by the United States government to recover damages and impose civil penalties for false claims for payment. The *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)–(h), authorize private citizens, acting as whistleblowers and designated as relators, to initiate FCA actions to benefit the federal government and to share in any recoveries. Individuals and businesses that "knowingly" submit false claims or fraudulent documentation to the federal government can be liable for damages and civil penalties. The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. The two largest categories of federal funding programs represented in FCA actions are health care and defense industry fraud. However, any fraudulent request for payment to the federal government or its agents, or to states where the program at issue is partially funded by the federal government, can give rise to an FCA action.

- The **Deficit Reduction Act of 2005** places a greater emphasis on detecting and preventing FWA within the Medicaid program. Specifically, Section 6302 of the DRA, codified at 42 U.S.C. § 1396a(a)(68), requires any entities that pay or receive annual Medicaid payments of $5 million or more to retain formal policies in combatting FWA for all employees.

- The federal **Anti-Kickback Statute (AKS),** 42 U.S.C. § 1320a-7, is a criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of federal health care program business. The AKS is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the AKS results in mandatory exclusion from participation in federal health care programs and may also result in a fine of up to $25,000 and imprisonment for up to five years. Absent a conviction, individuals who violate the AKS may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. The government may also assess civil monetary penalties, which could result in treble damages plus $50,000 for each violation of the AKS. Although the AKS does not afford a private right of action, the FCA provides a vehicle whereby individuals may bring qui tam actions alleging violations of the AKS. When a private citizen sues on behalf of the federal government and is successful, they receive a percentage of the ultimate recovery for their "whistleblower" efforts.

- The **Stark Law**, 42 U.S.C. § 1395nn, prohibits physician referrals of health services for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that entity. A financial relationship includes ownership, an investment interest, or a compensation arrangement. Referral services may include clinical laboratory tests; physical therapy services; radiology and ultrasound services; radiation therapy services and supplies; DME and supplies; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.

- The **Affordable Care Act** requires providers, Medicare Advantage Plans and Part D (Prescription Drug) Plans to report and return any overpayments within 60 days of discovery.

- The **Health Care Fraud Statute**, 18 U.S.C. § 1347, prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- The **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended, provides privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other providers.

- **CMS** requires insurers to maintain a Compliance program that includes measures to detect and prevent FWA.

- The **Health Care Fraud Prevention and Enforcement Action Team (HEAT)** was established by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force, which successfully fights fraud.

- Pursuant to the **Exclusion Statute**, 42 U.S.C. § 1320a-7, the HHS **Office of Inspector General (OIG)** must exclude from participation in all federal health care programs any provider or supplier convicted of:
    - Medicare fraud;
    - Patient abuse or neglect;
    - Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service; or
    - Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

  The OIG also has the discretion to impose exclusions on a number of other grounds. Excluded providers cannot participate in federal health care programs for a designated period. An excluded provider may not bill federal health care programs (including, but not limited to, Medicare, Medicaid and State Children's Health Insurance Program [SCHIP]) for services he or she orders or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic.

New York State:

- The **New York State False Claims Act**, N.Y.S. Fin. Law §§ 187–194, allows the Attorney General or any other person to file a lawsuit against a person or a company that obtains or withholds funds or property from the state or local government through false or fraudulent conduct. A person or company found liable under the act must generally pay treble damages, civil penalties, plus costs and attorneys' fees. Individuals who file suits may be eligible to keep

a percentage of the funds they help recover. The state False Claims Act also protects employees from being retaliated against for filing *qui tam* suits against employers who may be engaged in activities or practices that defraud the government of money or property.

- The **New York State Provider Compliance Program** regulations, 18 NYCRR SubPart 521-1 through 521-4, were updated in 2022 to include Managed Care Organizations (MCOs) in their scope of applicability. Under these regulations MCOs are required to have a robust Compliance Program, including a FWA prevention and detection system. The regulations provide definitions and general requirements for such programs.

- The **Social Services Law,** at § 145-b, makes it a violation to knowingly obtain (or attempt to obtain) payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the Local Social Services District may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. A penalty of up to $30,000 per violation may be imposed if repeat violations occur within five years and involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

- The **Social Services Law**, at § 145-c, states that if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least $1,000 but not more than $3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of $3,900), and five years for any subsequent occasion of any such offense.

- The **Penal Law Article**, at § 176, applies to claims for insurance payments, including Medicaid or other health insurance, and establishes six crimes ranging from Insurance Fraud in the 5th degree (a class A misdemeanor) through Insurance Fraud in the 1st degree (a class B felony). Furthermore, Aggravated Insurance Fraud (committing Insurance Fraud more than once) is a class D felony.

- **The Penal Law**, at § 177, addresses health care providers, including any publicly or privately funded health insurance or managed care plan or contract, who defraud the system. It also includes crimes ranging from Health Care Fraud in the 5th degree (a class A misdemeanor) through Health Care Fraud in the1st degree (a class B felony).

IV.INVESTIGATING FRAUD, WASTE AND ABUSE

A. Investigation Procedures

The Compliance Department investigates all reports of suspected FWA in accordance with SNH Policies and Procedures. SNH's Compliance Department consists of key organizational supervisors, department managers, and the Chief Compliance Officer.

The Compliance Department reviews all reports of potential FWA ("allegations") and determines—within two (2) weeks, or fourteen (14) calendar days, of receipt — whether a case must be initiated. If, during the timeframes set forth above, the Compliance Department determines that an allegation cannot be addressed by due to lack of resources, time or experience (e.g., provider/member collusion cases that require undercover and/or surveillance, or allegations of kickbacks or bribery), the Chief Compliance Officer will determine whether the case is referred to OMIG or another enforcement agency, as appropriate. In such instances, the referral is documented, and the case is closed. For referred cases, the Compliance Department promptly responds to any follow up required by OMIG or other enforcement agency, and logs its response in the associated case file. If a regulatory or law enforcement agency returns a case to the Compliance Department for investigation, the case is reopened and responded to in accordance with applicable state and federal laws and SNH policies and procedures.

If the Compliance Department determines that a case must be initiated in response to an allegation, an investigation is commenced within three (3) business days following the opening of a case. Once a case is opened, the Compliance Department logs the case in a database, noting the date the report was received, and establishes a case file (Note: In the case of FWA referrals from the Grievance & Appeals Department, the Grievance & Appeals Department provides the member or member representative with acknowledgment of receipt and notice of referral to the Compliance Department.).

The Compliance Department researches the validity of the report, obtains all necessary supporting documentation for the case file and analyzes this documentation. Such activities may include:

- Three year review, if applicable, of provider or member claims history;
- Review of billing and/or payment history or patterns;
- Review of prescribing/ordering history;
- Provider malpractice, sanctions and exclusions checks;
- Review of medical records;
- Interviews with providers and/or members;
- Review of prior cases involving the provider or member;
- Review of provider and/or member contacts with SNH; and
- Request for assistance from SNH Operational areas.

Only information that is factual and pertinent to the case is gathered during an investigation.

If an alleged perpetrator of the FWA claim does not forward the requested documentation by the requested deadline, the Billing Supervisor or designee will notify the provider advising of a claims offset from future claims if the request is left unanswered.

In all cases the Compliance Department makes best efforts to update any investigation, if possible, every thirty (30) days following receipt of any allegation.

B. Reporting to Federal and State Agencies

The Chief Compliance Officer or designee is responsible for notifying applicable federal and state agencies, and law enforcement as appropriate, of suspected FWA. Notified agencies may include OIG, DFS, the OMIG, or the New York State Medicaid Fraud Control Unit (MFCU).

These agencies provide specific forms and/or contact information for notification of suspected FWA. MFCU and the OMIG provide referral forms that can be transmitted by e-mail and toll-free phone and fax numbers; and OIG provides fax and phone numbers as well as an address for written complaints.

If during an investigation it is determined that potential FWA or other misconduct has occurred, the Chief Compliance Officer or designee forwards the potential referral to the legal department. If the legal department agrees with the Chief Compliance Officer's assessment, the Chief Compliance Officer or designee then reports that misconduct to the appropriate agency (DFS, the OMIG, OIG or MFCU) within seven (7) days, but no later than sixty (60) days, if appropriate, after the determination that a violation may have occurred.

For each case of FWA confirmed by the Compliance Department, the following information will be reported to OMIG:

- The name of the individual or entity that committed the FWA;
- The source that identified the FWA;
- The type of provider, entity or organization that committed the FWA;
- A description of the FWA;
- The approximate range of dollars involved;
- The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data/information as prescribed by NYSDOH.

Reports of all Fraud, Waste, and Abuse investigations are reported quarterly to the SNH Governing Board.

V. PROACTIVE DETECTION OF FRAUD, WASTE AND ABUSE

SNH devotes significant resources and effort to proactive detection of potential FWA, and—as listed below—has developed key initiatives and processes aimed at proactively detecting patterns and practices of FWA.

- SNH uses a clearinghouse, Change Healthcare, for Medicaid claim coding to identify waste and to prevent improper payments.

- SNH conducts education and awareness training efforts to maximize suspected FWA referrals from directors, officers, managers, other staff members, contractors, agents, and providers. These efforts are further described in the following section.

- SNH provides education to its members via its website to encourage FWA reporting form its members.

- SNH conducts periodic audits to verify with its members that services billed by providers were received, including:
    - On a quarterly basis, SNH verifies the delivery of billed services to its members by pulling statistically valid claims samples and contacting members to confirm that services billed were in fact received. When members report that billed services were not received, the Compliance Department investigates and takes appropriate corrective action, as necessary.
    - Annual audits of Social Adult Day Care (SADC) services are completed in compliance with DOH and CMS guidance, to ensure services are being provided to SNH members consistent with members' individualized plans of care.
    - Monthly randomized audits of Consumer Directed Personal Assistance Services (CDPAS) are completed to ensure SNH members are receiving services.

- The SNH billing office completes monthly randomized audits on claims received to identify overpayments.

- SNH works with its Electronic Medical Record provider, TruChart, to reject payments of duplicate claims. SNH department supervisors meet with TruChart development staff regularly to identify ways to improve FWA detection through utilization reviews and claims submittals.

VI.AWARENESS AND EDUCATION

SNH employs a variety of approaches to promote the awareness and the education of employees and delegated entities about FWA:

- The SNH website includes an FWA webpage accessible and publicized to directors, officers, managers, other staff members, members, providers and the public. The webpage provides information about FWA, tips on how to detect FWA and information on reporting.

- SNH works with its providers to investigate FWA reports, to share information about individual cases or fraud schemes of common concern and to coordinate responses when potential trends or patterns are identified.

- SNH requires its directors, officers, manager, and other staff members to complete annual training through the NetLearning system. NetLearning is a computer-based training system that allows SNH to ensure understanding through post-tests and timely completion of the module. Learning modules remain accessible to all staff for reference after completion.

- The Compliance Department and leadership maintain an open-door policy to communicate compliance concerns, suspected Code of Conduct violations and suspected FWA. This open-door policy is emphasized at every training opportunity.

VII. COMPLIANCE COMMITTEE AND REPORTING TO BOARD

On a quarterly basis, the Compliance Officer reports on FWA and its investigation activities (including trends, patterns, outcomes, corrective actions, and recoupment) to the Compliance Committee. FWA issues are also reported to the SNH Governing Board. Such reporting includes the financial impact of claims issues investigated.

The SNH Fraud Detection Manual is submitted to the SNH Governing Board annually for review.

VIII. COLLABORATION WITH LAW ENFORCEMENT AND OTHER HEALTH PLANS

The SNH Compliance Department respectfully cooperates with all requests for information from governing bodies, including local law enforcement and OMIG. SNH also has good working relationships with its providers and other MCOs to collaborate to detect and report any suspected FWA. SNH will coordinate with other health plans' FWA investigation personnel to share information on investigations, particularly when a scheme common to the plans' vendors or providers is suspected.

IX.EXCLUSIONS CHECKS AND RELATED MONITORING

SNH performs checks of all employees against exclusionary lists to ensure that it does not hire or employ persons, or contract with providers who have committed FWA or present a program integrity concern. These exclusionary lists include, as appropriate:

- OMIG List of Restricted, Terminated or Excluded Individuals or Entities;
- The Excluded Parties System / System for Award Management;
- The National Plan Provide Enumeration System;
- The OIG Exclusion List;
- The OIG Most Wanted Fugitives List;
- The New York State Office of the Professions Misconduct Enforcement System;
- The CMS Preclusion List; and
- SAM.gov

Any checks that raise a potential concern or that involve a question of correct identity are escalated to MVHS Corporate Compliance.

SNH also checks new medical and institutional providers and reenrolled providers, and performs verifications on all participating providers, against excluded provider lists including those listed above. All network providers are required by contract to monitor staff and managers against the exclusionary lists and to report any exclusions to SNH on a monthly basis. Potential issues identified by provider checks are monitored through reports to the Compliance Department.

SNH collects ownership and control disclosure information from managing employees for conflict of interest purposes.

X. FRAUD and ABUSE RESOURCES

Federal:

• HHS	www.hhs.gov
• CMS	www.cms.gov
• HEAT Task Force	www.stopmedicarefraud.gov
• OIG	www.oig.hhs.gov
• DEA	www.dea.gov
• DOJ	www.justice.gov
• Healthcare Fraud Prevention Partnership	www.hfpp.cms.gov
• FBI	www.fbi.gov

New York State:

• OMIG	www.omig.ny.gov
• MFCU	www.ag.ny.gov/bureau/medicaid-fraud-control-unit
• NYS Attorney General	www.ag.ny.gov
• NYS Physician Profile	www.nydoctorprofile.com
• NYS Professional Misconduct	www.op.nysed.gov/opd
• NYS Department of Health	www.health.ny.gov
• NYS Department of Financial Services	www.dfs.ny.gov

Private organizations:

• NHCAA	www.nhcaa.org
• ACFE	www.acfe.com
• Coalition Against Insurance Fraud	www.insurancefraud.org