PREMIER ACCESS

ACCESS DENTAL

Policy and Procedure			
Policy Name:	Fraud & Abuse	Policy ID:	QM.038.01
Approved By:	Dental Director (signature on file)	Effective Date:	1/1/2013
States:	All States	Revision Date:	N/A
Application:	All Programs		

This policy applies for operations under Premier Access Insurance Company and Access Dental Plan. For the purposes of this Policy, Premier Access Insurance Company and Access Dental Plan shall be collectively referred to as "Premier Access".

Purpose

Pursuant to certain provisions of the Deficit and Reduction Act of 2005, the purpose of this policy is to inform employees about (1) Premier Access' compliance plan for detecting and preventing fraud and abuse, and (2) federal and state false claims laws and the protections provided for employees who report suspected false claims. Each employee is responsible for following the company's policies and procedures including using good faith efforts to comply with applicable laws and conduct business in an ethical and legal manner.

Policy

Premier Access maintains a compliance plan in order to detect and prevent fraud and abuse. Premier Access employees and providers are educated on the information necessary to detect and protect against fraud and abuse from occurring within Premier Access operations. Training occurs through the initial employee orientation process and is ongoing through various compliance activities which occur on an annual basis.

Definitions

Abuse - 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).

Claim – any request or demand, whether under a contract or otherwise, for money that is made to a contractor, if the United States Government provides any portion of the money that is requested or demanded, or if the Government will reimburse such contractor, for any portion of the money that is requested or demanded.

Fraud **-** 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).

Knowingly – to have actual knowledge of information, to act in deliberate ignorance of the truth or falsity of the information, or to act in reckless disregard of the truth or falsity of the information.

Prosecuting authority - refers to the county counsel, city attorney, or other local government official charged with investigating, filing, and conducting civil legal proceedings on behalf of, or in the name of**.**

Person - any natural person, corporation, firm, association, organization, partnership, limited liability company, business, or trust.

Suspected Fraudulent Claims (SFC) **–** Claim (or activity) that is identified to be potentially fraudulent or abusive in nature.

Procedure

Federal False Claims Act

Under the Federal False Claims Act, any person who does any of the following is liable to the United States Government:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;

California False Claims Act

Any person who commits any of the following acts shall be liable to the state for three times the amount of damages which the state or the political subdivision sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state for the costs of a civil action brought to recover any of those penalties or damages, and may be liable to the state for a civil penalty of up to ten thousand dollars ($10,000) for each false claim:

- Knowingly presents or causes to be presented to an officer or employee of the state thereof, a false claim for payment or approval.
- Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state.
- Conspires to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or by any political subdivision.
- Is a beneficiary of an inadvertent submission of a false claim to the state subsequently discovers the falsity of the claim, and fails to disclose the false claim to the within a reasonable time after discovery of the false claim.

Whistleblower Protections

The Federal and California False Claims Acts provide protection for individuals who report suspected false claims (whistleblowers).

1. Premier Access assures that whistleblowers will not be subjected to reprisal, harassment, retribution, discipline or discrimination by the company or any of its employees based on having made the report.

2. 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 Premier Access.

3. Protection is also provided for employees who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

Types of Fraud and Abuse

1. Member fraud or misrepresentation includes, but is not limited to:
   - Altering health records;
   - Altering referral forms;
   - Allowing another individual use of a Medicare or Premier Access card for the purpose of obtaining benefits.

2. Provider fraud and abuse includes, but is not limited to:
   - Falsification of provider credentials;
   - Billing for services not provided;
   - Double billing, upcoding, and unbundling; and
   - Collusion (providers agree on minimum fees they will charge and accept).

Responsible Parties

1. Every department is required to monitor fraud and abuse and follow the procedures described in this policy and procedure document.

2. The following Plan positions have a critical role in the detection and prevention of fraud and abuse due to the nature of their role and direct exposure to potential fraud and abuse activity:
   - Claims Examiners
   - Customer Service Representatives
   - Dental underwriters, other underwriting enrollment review staff
   - Pre-authorization review Staff
   - Eligibility Staff
   - Provider Relations Staff

3. The Fraud Officer shall be responsible for the following:
   - Logging and conducting initial review of Suspected Fraudulent Claim Referral Forms
   - Evaluating the need for additional investigation
   - In cases where further investigation is required after review , forward suspected cases of fraud to the Contracted Investigator for investigation
   - Reporting fraudulent claims with the appropriate federal and/or state agencies

4. Premier Access shall utilize the services of a Contracted Investigator to conduct further investigation of suspected cases of fraud forwarded by the Fraud Officer. The Contracted Investigator shall coordinate, as needed, with local and / or federal law enforcement agencies.

5. Premier Access shall utilize the services of Outside Counsel to support its fraud prevention and detection activities.

6. In the event that a suspected fraudulent claim or activity is identified, the employee is required to complete a Suspected Fraud Referral Form and submit it to the Fraud Officer for review.

Detecting Suspected Fraud and Abuse

1. Premier Access Departments identify potential member and provider fraud and abuse through various methods including, but not limited to, the review of following:
   - Referrals, claims and utilization;
   - Auditing/routine quality improvement audits;
   - Provider billing patterns;
   - Approvals or denials of health services to members;
   - Complaints or grievances filed by members, providers or employees; specifically issues related to underutilization of services, refusal to refer and other treatment related issue.
   - Member customer service inquiries; and
   - Medical records, specifically for referral patterns and quality of care issues.

2. Premier Access personnel shall review all "red flags" or "red flag events," or other situations suspected as potential fraudulent activity. Information regarding red flags and red flag events is provided for personnel as part of the fraud and abuse employee training sessions.

3. Claims Processing:
   - Built into Premier Access' 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, frequency limitations, coordination of benefits, duplicate claims and referral or other authorization requirements.
   - If a particular provider appears to have a pattern of inappropriate billings, an audit of past billings shall be conducted.

Suspected Fraudulent Claim Referral

1. When a suspected fraudulent activity or claim is identified, the Premier Access employee shall complete the Referral Form with all relevant information and attach documentation available.

2. The completed Referral Form and documentation shall be forwarded to the Fraud Officer immediately.

3. Fraud Officer shall review the Referral Form and documentation for completeness.
   - Fraud Officer shall log SFC into current year Referral Log.
   - Fraud Officer shall determine whether all necessary information and documentation regarding the nature and circumstances of the SFC has been submitted, and if not, shall contact the referring party or other internal departments for additional information.

- If additional investigation is required, Fraud Officer shall prepare a written summary and mail the summary, referral form and all other material documentation to the Contracted Investigator.

- After a file has been investigated by the Contracted Investigator, and the investigative documentation and filing form have been forwarded to the Fraud Officer, the Fraud Officer shall update the log for the case, and submit the filing form and documentation to the DHCS.

4. For cases forwarded to the Contracted Fraud Investigator, the Contracted Fraud Investigator shall conduct such investigations as he or she deems necessary to establish the validity of the claims.

   - Contracted Investigator shall prepare a filing form for all suspected fraudulent claims which he or she has investigated and validated with supporting documentation and submit it to the Plan.

5. Employees have the option to anonymously report suspected fraud/activity.

6. Suspected fraud/activity may also be reported directly to the Federal Department of Health and Human Services. The Office of the Inspector General maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

   Phone: 1-800-HHS-TIPS
   Fax: 1-800-223-2164
   Email: HHSTips@oig.hhs.gov
   Mail: Office of the Inspector General
   General HHS TIPS Hotline
   P.O. Box 23489 Washington, DC 20026

Education and Training

1. Premier Access shall provide training on fraud and abuse prevention and detection on an annual basis. Training sessions shall be conducted by the Fraud Officer or each Department Manager.

2. All staff involved in claims adjudication, dental underwriting, eligibility approval, service pre-authorization, customer service and provider relations shall be required to attend fraud training annually.

   All participants in each training session shall sign a log indicating the date and nature of the training session. The logs shall be retained by the Fraud Officer as a permanent record.

3. Premier Access Employee Handbook includes information regarding the False Claims Act and Access' Fraud and Abuse Prevention and Detection policies.

4. Premier Access shall distribute information regarding the False Claims Act and Access' Fraud and Abuse Prevention and Detection policies to its contracted providers on an annual basis. This information shall also be included in the Provider Manual.

Reporting

Premier Access shall submit the Anti-Fraud Annual Report to the California Department of Managed Health Care (DMHC) or applicable regulatory agency, summarizing the Plan's fraud prevention and detection activities and SFC's identified for the period.

References

This policy was previously tracked as Quality Management Program Policy and Procedure **QM-35 – Fraud & Abuse**.

Revision History

Date:	Description
01/01/2013	Conversion to new policy and procedure format and naming convention.

EXHIBIT A
Fraud & Abuse
Suspected Fraud Referral Form

SUSPECTED FRAUD REFERRAL FORM
Special Investigation Unit (SIU)

TO: **Terri Abbaszadeh, SIU Liaison**

FROM: ______________________________ **DEPT**.________________________

DATE OF REFERRAL: ____________________

DESCRIPTION OF SUSPECTED FRAUD:

____
____
____
____
____

Provider's Name (if applicable): _________________________Phone:_______________
Provider's Address: ____

Member's Name: ________________________________ **Phone:** __________________
Member's Address: ____

Is Documentation Attached? Yes ______ No _________

Description of Attached Documentation:

____
____

Additional Comments (if any)

____
____

*Please do not write below this line*____

SIU Referral Tracking Documentation

Date Form was received and logged: ____________________
Referral Log Number:________________________________
Requires additional Investigation?: ____
Forwarded to Investigator?______________ Date Forwarded: ____________
Any further action required? _____________ **Forwarded to CDI or D.A.? _____________**
Final Disposition of Referral:

____
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Additional Comments: ____
Date File was Closed: ______________________________