

Upper Peninsula Health Plan
Policy & Procedure

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Subject:	Procedures to Detect Fraud And Abuse	Revised:	03/24/08; 03/10/2010
		CEO Approval:	03/10/2010

Authorized By: _____ **Date:** 3/10/2010 **Title:** CEO

Purpose

The Center for Medicare and Medicaid (CMS) and the State of Michigan Department of Community Health Medicaid Integrity Section require Medicare and Medicaid Health Plans to identify ways to detect and report fraudulent activities. This policy describes and outlines the detection and reporting of member, provider and health plan fraud and abuse.

Definitions

f. **Fraud:** An 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 the applicable Federal or State law. 42 CFR 455.2

Abuse: 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 beneficiary practices that result in unnecessary cost to the Medicaid program. 42 CFR 455.2

Policy

The Upper Peninsula Health Plan, Inc. (UPHP) is committed to conducting its affairs in accordance with applicable laws and to maintaining a policy on fraud and abuse that abides by accrediting agency guidelines and local, state and federal regulations. To this end, the UPHP strives to assure that its business practices are held to exceptional standards and that policies and procedures are in place to detect and report fraud, waste and abuse. Additionally, claims for reimbursement are submitted not only in compliance with applicable law, but also the applicable requirements of third party payment (TPA) programs.

Procedure

The UPHP will appoint a Compliance Officer for the health plan and will establish a Compliance Committee that is composed of senior staff from the following departments: Information Systems; Customer Service; Clinical Services; Pharmacy; Claims and Finance. The Compliance Officer will act as the liaison between the health plan and the Michigan Department of Community Health (MDCH) Program Investigation Section and the Center for Medicare and Medicaid (CMS).

- a. & c. The Committee and Compliance Officer shall meet at least quarterly to review Management Reports from the departments to identify potential fraud and abuse by Providers and Members. The Compliance Officer will report directly to the Chief Executive Officer and will provide a yearly report on compliance activity to the Board of Directors.

Examples of potential Provider fraud and abuse are: billing for services not rendered; billing without reporting other sources; billing for a brand- name drug not dispensed; billing for unnecessary services; billing a date of service other than the actual date the service was rendered; and the over prescribing of controlled substances.

Additionally, reports from the Customer Service, Claims, Clinical, and Pharmacy Departments will be used to identify the following for UPHP Members: misuse of Member ID Card; presenting for service without an ID card; overuse of controlled substances; inappropriate use of services; and the altering of medical record documents.

Internally, the UPHP has placed the following controls within its organization to prevent fraud and abuse from occurring: the UPHP segregates duties and establishes barriers surrounding authorization, claim payment, check cutting and the provider entry functions; the UPHP maintains a Check Writing Policy (102-002) that requires two signatures; the UPHP claims department has set up a system of controls to monitor for provider and member fraud and abuse; inter rater reliability for the Clinical and Pharmacy Departments; and the UPHP finance department conducts claim payment audits of the claims department. These procedures are further elaborated upon in UPHP's Compliance Auditing/Monitoring Plan.

Internal and External Audits

Under the direction of the Chief Financial Officer, who shall oversee and coordinate such activities with the UPHP Chief Executive Officer (CEO), a random sample of medical claims paid monthly shall be reviewed by the Quality Assurance Analyst and any discrepancies found will be taken each quarter to the Compliance Committee and Compliance Officer. The CEO may engage a qualified external consultant to evaluate a representative sample of medical records and corresponding claims submissions to assess the appropriateness of documentation and claims submitted. Such external review can, but need not be, accomplished in connection with the annual audit of the UPHP. The

results of the audit will be used to determine whether any review action is warranted based on the audit findings.

Prohibited Affiliation with Individuals Debarred by a Federal Agency

UPHP will not pay or affiliate itself with any individual that has been debarred by a Federal Agency. See UPHP policy 200-005.

Reporting and Investigation of Alleged Fraud and Abuse

b. Any employee, enrollee/family member, or provider of the UPHP who suspects an improper or illegal activity associated with the UPHP is required to report such suspicion to the Compliance Officer. Any employee, enrollee/family member or provider who reports such matters shall not be subjected to retaliation or harassment in any manner and any employee of the UPHP engaging in such conduct will be subject to discipline up to and including termination.

For all incidents of fraud and abuse within any of the federal or state programs, the Compliance Officer will report this directly to the MDCH Medicaid Integrity Program (for Medicaid) and to CMS for federal programs (Medicare). The UPHP will not attempt to investigate or resolve the reported suspension, knowledge or action without informing the MDCH. The UPHP will cooperate fully with the MDCH in the investigation.

Corrective Action Plan

Whenever the UPHP Compliance Committee identifies an issue for which corrective action is indicated, the Compliance Committee shall develop a formal plan to address the issue. Such a plan can include, without limitation, additional education and/or training, seeking clarification from appropriate personnel and/or obtaining the advice of legal counsel and/or outside consultations.

The purpose of all corrective action plans will be to appropriately address the issue, to bring the UPHP into legal compliance and to consider actions that may facilitate ongoing compliance. The Compliance Officer shall be responsible for determining whether certain individuals or groups of individuals are responsible for particular compliance problems and shall determine the degree of monitoring required for such individuals or groups of individuals.

Penalties for Fraud and Abuse

Depending on the situation, abusive or questionable practices can be dealt with in a wide variety of ways ranging from educational contacts to conviction and jail time – and not just for Medicaid or violations. Under the provisions of HR 3103, the application of certain criminal penalties for violations for fraud and abuse under Medicare and Medicaid are extended to similar violations in other federal health care programs. Federal health care programs are defined as “any plan or program that provides health benefits, which are funded directly, in whole or in part, by the United States government.”

Administrative Remedies

To correct abusive practices, administrative remedies may be initiated. These may include provider education, recovery of overpayments, withholding payments, or referrals to state licensing boards of medical and professional societies or to peer review organizations.

e. Education Regarding Fraud and Abuse

The UPHP will educate employees, providers and members on its detection and elimination of fraud and abuse in the following manner:

1. Employees will have no less than a yearly in-service on UPHP internal controls for detecting fraud and abuse with members, providers and UPHP staff and the procedures to follow to report suspected fraud and abuse to Supervisors and to the Michigan Department of Community Health Program Investigation Section.
2. The UPHP will have a section on fraud and abuse in its Provider Manual with contact information for the health plan and MDCH Program Investigation Section if they suspect fraud and abuse with members, other providers or UPHP personnel. UPHP will also publish one article a year in its Provider Newsletter relating to detection of Medicaid fraud and abuse.
3. The UPHP will have a section on fraud and abuse in its Member Handbook with contact information for the health plan and the MDCH Program Investigation Section if they suspect fraud and abuse with members, other providers or UPHP personnel. UPHP will also publish one article a year in its Member Newsletter about fraud and abuse with Medicaid.

Exception to this policy may be made with the approval of the Chief Executive Officer or an authorized designee.

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