

Upper Peninsula Health Plan
Policy & Procedure

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Subject:	Procedures to Detect Fraud And Abuse	Revised:	9/01/04
		CEO Approval:	9/01/04
Authorized By:	_____	Date:	_____ Title: CEO

Purpose

The Center for Medicare and Medicaid (CMS) requires 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 plan fraud and abuse.

Definitions

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 all 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.

The Committee and Compliance Officer will meet quarterly to review Management Reports from the departments to identify potential fraud and abuse by Providers. The Compliance Officer will report yearly to the Board of Directors on Committee activity. Examples of potential 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 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 Clinical Advisory Committee will provide varying levels of oversight and decision making for Plan policies and activities; 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 third party administrator (TPA) conducts regular claim payment audits of processors; and the UPHP Claims Supervisor conducts claim payment audits of the TPA.

Internal and External Audits

Under the direction of Chief Financial Officer (CFO), who shall oversee and coordinate such activities with the UPHP Chief Executive Officer (CEO), a representative sample of medical claims submissions shall be reviewed each quarter by 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.

Reporting and Investigation of Alleged Fraud and Abuse

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 suspension or knowledge of fraud and abuse within any of the MDCH programs, the Compliance Officer will report this directly to the MDCH Program Investigation Section. 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 CEO 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 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.

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 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 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 information on contacting the health plan 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.

///END OF POLICY & PROCEDURE ///