

	<b>PCHP Fraud Waste and Abuse Piedmont Community Health Plan</b>	
	Name:	PCHP.FWA.101 Comprehensive Fraud Waste and Abuse Program
	ID Number:	PCHP.FWA.101
	Start Date:	02/06/2016
	Approval Date:	02/06/2016
	Review Date:	02/06/2018
	Approved By:	Garland Morton/CentraNotes

## Body

**Policy Name:** Comprehensive Fraud and Abuse Plan

**Scope:** Entire Piedmont Workforce

**Purpose:** To ensure an efficient and effective program that detects and prevents fraud, waste and abuse in accordance with Federal and State laws, regulations and guidance.

### **Definitions & Acronyms:**

PCHC: Piedmont Community HealthCare (Piedmont)  
 CMS: Centers for Medicare & Medicaid  
 CFR: Code of Federal Regulations  
 FDR: First Tier, Downstream and Related Entities  
 PBM: Pharmacy Benefit Manager  
 FWA: Fraud, Waste and Abuse

**Piedmont:** "Piedmont" collectively refers to Piedmont Community Health Plan (PCHP), Piedmont Community HealthCare (PCHC) and any future entities that are owned, affiliated with and/or operated by Piedmont

### **Policy:**

Piedmont Community HealthCare shall implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.

PCHC has adopted Policies and Procedures for each of the seven core elements of a compliance plan, designed to integrate a fraud, waste and abuse program inside of the plan, and as required by regulation, including:

- Written Standard of Conduct and Policies and Procedures
- Designation of a Compliance Officer and Compliance Committee
- Effective Compliance Training
- Effective Lines of Communication
- Disciplinary Mechanisms
- Internal Monitoring and Auditing
- Procedures for Responding to Detected Offences

This Fraud, Waste and Abuse Policy covers the following elements:

- A. Responsibility for Compliance
- B. Responsibility for Identifying Fraud, Waste and Abuse
- C. Detecting Violations of Fraud, Waste and Abuse
- D. Actions to be Investigated

- E. Monitoring in place to guard against Fraud, Waste and Abuse
- F. Procedures for Employees to Report Fraud and Abuse
- G. Procedures for Delegated Entities to Report Fraud and Abuse
- H. Responding to Possible or Detected Violations
- I. Suspensions/Terminations of Providers
- J. Suspensions/Terminations of Members
- K. Fraud and Abuse Sanctions
- L. Recovery and/or Adjustment of Identified Fraud and Abuse Payments
- M. Violations
- N. Record Retention

**Procedures:**

**1. Responsibility for Compliance**

Every individual within each department of PCHC and delegated entities has the responsibility to comply with applicable statutory, regulatory and other requirements including but not limited to the following:

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Prohibition Statute (Stark Law)

**2. Responsibility for Identifying**

Every individual within each department of PCHC and delegated entities has the responsibility for identifying irregularities in the business and utilization practices of providers, vendors, members, or employees.

**3. Detecting Violations of Fraud and Abuse**

**A. Laws and Regulations**

PCHC will make every effort to identify violations of the following laws and regulations:

1). The Federal False Claims Act:

- The Federal False Claims Act (31 U.S.C. §3729 – see Attachment A) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, like a carrier, other claims processor, or state Medicaid program.
- In addition, PCHC will follow The Federal False Claims Act (31 U.S.C. §3802) in pursuing remedies for false claims and statements, as defined in Attachment B.
- Whistleblowers are also offered certain protections against retaliation for bringing an action under the Act. Employees who are discharged, demoted, harassed, or otherwise confront discrimination in furtherance of such an action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages including litigation costs and reasonable attorneys' fees.

2). The Anti-Kickback Statute:

- Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b) – see Attachment C) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare Advantage or other Federal health care programs. For the purpose of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

3). Stark Law:

- The Stark Law prohibits physicians from making referrals for a "designated health service," payable by Medicare or Medicaid, to any entity with which the physicians have a financial relationship. A financial relationship means either an ownership interest or a compensation arrangement. Penalties for violating the Stark Law include denial of payment for the service, civil monetary penalties, or even the possibility of being excluded from Medicaid, Medicare Advantage or other government programs.

B. Code of Conduct and Policies and Procedures

- 1). PCHC's Code of Conduct is intended to promote commitment to compliance and a culture of integrity in all employee and business interactions. Every employee of PCHC or employee of a delegated entity who conducts business with PCHC shall be responsible for adhering to PCHC's Code of Conduct. The Code is posted on PCHC's intranet and all delegated entities are provided with the Code annually.
- 2). Policies and Procedures specific to affected areas of the company's operations shall be developed and kept current with applicable laws and regulations. These policies and procedures shall be the resource for employees and will be designed to enhance the ability of employees to perform their responsibilities in compliance with the Compliance Program and applicable laws and regulations. The department director in each area is responsible for ensuring that compliance standards are maintained in accordance with this policy.

C. Compliance Officer and Compliance Committee

PCHC has designated a Compliance Officer and Compliance Committee charged with the responsibility of ensuring PCHC is adhering to its corporate commitment to detect, correct and prevent fraud, waste and abuse as described in policy PCHP.CP.102 – Compliance Officer, Committee and High Level Oversight.

D. Training

Piedmont provides training and education on ways to detect, correct and prevent FWA as described in policy CP03 – Effective Training and Education. Training is required as part of orientation for new employees and is required annually for all employees, including the CEO and other senior management, Board of Directors, and first tier, downstream, and related entities.

4. Actions to be Investigated

- A. It is PCHC's policy to investigate any action by providers, vendors, members, employees or delegated entities that affects the integrity of Medicaid, Medicare Advantage, and/or other government programs. Such actions include suspected fraud/abuse and quality issues. Quality issues are those which on an individual basis affect the member's health or the program's integrity. Examples of fraud/abuse and quality actions include, but are not limited to:

Falsifying claims/Encounters	Delivery of Services
Alteration of Claim Denying access to services/benefits	
Incorrect Coding	Limiting access to services/benefits
Double Billing	Failure to refer for needed services
Billing for services not provided	Under-utilization
Misrepresentation of services/supplies	Over-utilization
Substitution of services	Member Eligibility Fraud
Kickback/Stark violations	Eligibility determination issues
Fraudulent credentials	Resource misrepresentation
Fraudulent enrollment practices	Residency
Fraudulent recoupment practices	Household composition
Embezzlement	Citizenship Status
Member abuse	Prescription alteration/forgery
Neglect	Durable Medical Equipment theft
Discrimination	Misrepresentation of medical condition
Providing substandard care	Failure to report third party liability

B. Opportunities for FWA in a government prescription drug program include but are not limited to:

- Billing for services not furnished and/or drugs not provided
- Billing non-covered prescription as covered items
- Billing for expired drugs
- Dispensing without a prescription
- Billing for recycled prescription drugs
- Billing for brand when generics are dispensed
- Altering scripts or data to obtain a higher payment amount
- Misrepresentations of dates, descriptions of prescriptions or services

**5. Monitoring Fraud and Abuse**

- A. PCHC has developed, and shall continue to develop and refine, procedures for effective internal monitoring and auditing for FWA and conduct Risk Assessments to detect and prevent FWA as described in Policy No. PCHP.CP.106 – Internal Monitoring and Auditing Work Plan.
- B. Additionally, Piedmont will use data analysis to identify unusual patterns suggesting potential errors and/or potential fraud and abuse. Data analysis should:
- 1). Establish baseline data to enable Piedmont to recognize unusual trends, changes in drug utilization over time, physician referral or prescription patterns, and plan formulary composition over time;
  - 2). Analyze claims data to identify potential error, inaccurate TrOOP account, and provider billing practices and services that pose the greatest risk for potential FWA;
  - 3). Identify items or services that are being over utilized;
  - 4). Identify problem areas within the plan such as enrollment, finance, or data submission;
  - 5). Identify problem areas at the FDR (e.g., PBM, pharmacies, pharmacists, physicians, other health care providers and suppliers); and
  - 6). Use findings to determine where there is a need for a change in policy.
- C. Piedmont will develop indicators that will be used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends. Examples include:
- 1). Standard deviations from the mean;
  - 2). Percent above the mean or median; and
  - 3). Percent increase in charges, number of visits/services from one period to another.
- D. Piedmont should routinely generate and review reports on pharmacy billing, medical claims, etc. based upon the data analysis performed to identify pharmacies and other FDRs that require further review.

**6. Procedures for Employees to Report Fraud and Abuse**

Once fraud and abuse is suspected, employees should refer to Policy No. PCHP.CP.104 – Effective Lines of Communication on various methods available to report. Failure to do so could result in employee disciplinary action.

**7. Procedures for Delegated Entities to Report Fraud and Abuse**

- A. Once the fraud and abuse is suspected, the appropriate policies and procedures within the parent organization should be followed.
- B. Employees of delegated entities may also report suspected violations to PCHC following the procedures referred to in Policy PCHP.CP.104 – Effective Lines of Communication.

**8. Responding to Possible or Detected Violations**

PCHC is committed to investigating any incident of noncompliance with the Compliance Program, significant failures to comply with applicable federal or state law, and other types of misconduct which threatens or calls into question PCHC's status as reliable, honest, and trustworthy, as described in Policy PCHP.CP.107 – Prompt Response to Compliance Issues. This includes initiating corrective action plans

as appropriate, and voluntarily self-reporting potential fraud or misconduct to a government program to CMS or its designee and other law enforcement agencies.

#### **9. Suspensions/Terminations of Providers**

- PCHC will immediately act to terminate a provider upon notification from any regulatory agency that a provider with whom it has entered into an agreement is suspended or terminated from participation in Medicaid, Medicare Advantage or other government programs. PCHC will review the LEIE list generated by the Social Security Act §1128 to identify individuals rendering services on behalf of PCHC members that are excluded from Medicaid, Medicare Advantage or other government programs.
- Terminations for loss of licensure and/or criminal convictions will be effective as of the date of action.
- In addition, the Compliance Officer or CEO will immediately notify the appropriate regulatory agency, in writing, if a provider or subcontractor with whom it has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the program after commencement of an action by PCHC to suspend or terminate the provider.

#### **10. Suspensions/Terminations of Members**

- PCHC will immediately act to terminate a Medicare Advantage or other government program member upon confirmation that a member has violated any act as identified by the False Claims Act (31 U.S.C. §3729 – see Attachment A) relating to prohibited acts, criminal penalties, and civil remedies.
- In addition, PCHC will immediately notify the appropriate regulatory agency, in writing, if a member is subsequently suspended, terminated or voluntarily withdraws from participation in the program after commencement of an action by PCHC to suspend or terminate the member.
- Following this written notification, the Compliance Officer will notify the enrollment department of the intent to suspend or terminate and begin the involuntary disenrollment due to fraud based on the Disenrollment policy DN09 – Involuntary Disenrollment for Fraud or Abuse.

#### **11. Fraud and Abuse Sanctions**

- The appropriate regulatory agency will impose sanctions as deemed appropriate where there is evidence of violations involving fraud and abuse issues. Refer to Attachment C for a list of sanctions as defined by the Social Security Act §1128. Refer to Attachment A for sanctions as defined by The False Claims Act (31 U.S.C. 3729).

#### **12. Recovery and/or Adjustment of Identified Fraud and Abuse Payments**

- PCHC will aggressively pursue recoveries of any amounts paid by PCHC that relate to identified fraud and abuse activities. These recoveries and/or adjustments will be made in regards to all federal and state laws and the requirements for penalties that apply to each law or regulation.

#### **13. Violations**

- Knowledge of a violation or potential violation of this policy must be reported promptly to mitigate the effects on PCHC. In some instances, there is an obligation to report violations of law and policy to various state and federal agencies, its responsible designee and/or to law enforcement. Disciplinary actions can be imposed for non-compliance, including oral or written warnings or reprimands, suspensions, terminations, loss of contract, and financial penalties.
- Department Directors, in consultation with the Compliance Officer, shall help ensure that appropriate and consistent disciplinary action is taken against any employee responsible for any misconduct or non-compliance, as well as any employee responsible for the failure to prevent, detect, or report any violation.
- Disciplinary action will take into consideration, among other things, the nature of any violation, the impact or potential impact on the company, whether the violation was knowing or willful, whether the employee voluntarily reported his or her own violation, whether the employee attempted to hide or cover-

up the violation, and the extent to which the employee cooperated fully in the investigation and correction of the violation.

- Violations of this policy may result in disciplinary actions up to, and including, termination of employment as determined by the Department Directors in conjunction with the Compliance Officer.

**14. Record Retention**

- All violations, investigations, referrals, and reports will be maintained in accordance with PCHP.ADM.101 Policy Records Management and Retention.

**Equipment:** None

**Forms and Letters:** None

**Reference(s):** [42 CFR Sections 422.503\(b\)\(4\)\(vi\)\(H\), 423.504\(b\)\(4\)\(vi\)\(H\)](#); Medicare Managed Care Manual, Chapter 21 and Prescription Drug Benefit Manual, Chapter 9 (Rev. 1-11-13) – Compliance Program Guidelines, Sections 50.1 & 50.6.9.

**Interdisciplinary Review:** None

**Policy History:**

Date	Revision No.	Reason for Change	Sections Affected
01/19/2011	Draft		All
07/22/2011	NEW	<ul style="list-style-type: none"> <li>▪ Policy template modified changing header and adding Definitions and History sections</li> <li>▪ Approved by Compliance Committee</li> </ul>	All
07/12/2012	1.0	<ul style="list-style-type: none"> <li>▪ Responsible Area/Dept updated to include Delegated Entities</li> </ul>	Header
04/19/2013	2.0	<ul style="list-style-type: none"> <li>▪ Reformatted Policy Header</li> <li>▪ Updated policies and procedures in conjunction with issuance of new Chapters 9 and 21 of the PDBM and MMCM.</li> <li>▪ Added data analysis criteria to auditing and monitoring procedures.</li> <li>▪ Added cross references to applicable Compliance Policies and Procedures.</li> </ul>	Header, Policies and Procedures
03/04/2014	2.0	<ul style="list-style-type: none"> <li>▪ Annual Review. No changes.</li> </ul>	None
02/05/2016	2.1	<ul style="list-style-type: none"> <li>▪ Updated to Centra Format</li> </ul>	

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<p><b>Attachment Manager</b></p> <p>Attachments List:</p>					
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