Banner University Health Plans

POLICY and PROCEDURE

TITLE: CP 5018 Fraud, Waste and Abuse			
Version: 17	**Responsible Position:** Director of Compliance	**Responsible Department:** Compliance	
Origination Date: 07/01/2010	**Last Review Date:** 05/06/2020	**Approval Date:** 06/05/2020	**Next Review Date:** 06/15/2021
Organization: Banner University Health Plan, BUHP Compliance (CP)			
Population (Define): This policy applies to all lines of business			
Policy Replaces: AD 100 SNP, CP 100 SNP; CP 1100 A; CP 1100 S, CP 6018			

I. Purpose/Expected Outcome:

A. Prevention, detection, control and reporting of Fraud, Waste and Abuse.

II. Definitions:

A. Please refer to the link below for full definitions for the following terms:
http://sharepoint/sites/hppandp/new/Lists/Definitions/PP%20Definitions.aspx

III. Policy:

A. In support of the Health Plan Compliance Program, it is the policy of the Health Plan to detect, prevent and control member and provider-related Fraud, Waste and Abuse (FWA) within the Medicare and Medicaid systems. To meet this goal, the Health Plan is committed to comply with applicable statutory, regulatory and other requirements, sub-regulatory guidance and contractual commitments related to the delivery of Medicare and Medicaid benefits. The Health Plan has a written FWA plan to employ controls to prevent, detect and control potential cases of Fraud, Waste and Abuse. Additionally, this policy outlines the mechanisms utilized within the Health Plan to detect and prevent fraud and abuse.

IV. Procedure/Interventions:

A. The Health Plan is committed to comply with applicable statutory and regulatory guidance, sub-regulatory guidance, contractual commitments, and other requirements related to the delivery of Medicare and Medicaid Systems benefits, not limited to the following:
   1. Federal False Claims Act
   2. The administrative remedies for false claims and statements
   3. Anti-Kickback Statute
   4. Deficit Reduction Act of 2005 (DRA)
   5. Social Security Act
   6. Prohibition on inducements to members
   7. Health Insurance Portability and Accountability Act (HIPAA)
   8. Other applicable criminal statutes

9. Code of Federal Regulations (CFR), specifically CFR § 400, 403, 411, 417, 422, 423, 1001 and 1003.
10. AHCCCS ACOM 103 Fraud, Waste and Abuse
11. All sub-regulatory guidance produced by CMS for Part C and Part D such as manuals, training materials and guides
12. Applicable civil monetary penalties and exclusions and preclusions
13. Applicable provisions of the federal food, drug and cosmetic act
14. Applicable state laws relating to civil or criminal liability or penalties for false claims and statements
15. Whistleblower protections under the Federal False Claims Act or any applicable state laws
16. Contractual commitments

B. The Health Plan has a Compliance Program and Fraud, Waste and Abuse Plan (FWA Plan).
   1. The Compliance Program and FWA Plan is reviewed and updated annually.
      a. The Compliance Program and FWA Plan is available on the Banner Health intranet under Compliance and Ethics for all Health Plan employees and Board Members and available to agents and First Tier, Downstream and related Entities (FDRs) on the Health Plan websites. It is also posted on the Health Plan Policy and Procedure Share Point.
      b. Health Plan Employees receive training on the Banner Health Compliance Program as part of the Banner Health Compliance training in Banner Learning Center (BLC). They also receive training on the Health Plan Compliance Program and Fraud Waste and Abuse Plan through the BLC and are required to acknowledge that they have reviewed and understand the Health Plan Compliance Program and Fraud Waste and Abuse Plan. The Health Plan Code of Conduct is part of this document. All employees are required to complete these trainings.
   2. New employees need to complete these trainings within 60 days of hire (Note: during National/State emergencies due dates were extended to 120 days). The trainings are provided to all other employees annually.
   3. FDRs contracted with the Medicare or Medicaid Program are required to attest annually that they have adopted the Health Plan Code of Conduct and Compliance Policies or have adopted their own Code of Conduct and Compliance Policies that are materially similar in content.
   4. As a part of the training, employees are provided information on fraud, waste and/or abuse prevention, recognition and reporting including the obligation to report without fear of retaliation.

C. Prevention/ Detection of FDR Fraud, Waste and Abuse.

1. The Health Plan has in place, internal and external controls, policies and procedures that are capable of preventing, detecting, reporting and controlling Fraud, Waste and Abuse activities of FDRs, to include FDRs in the Health Plan Network and FDRs delegated to perform Health Plan administrative functions. For example, operational policies and controls such as claims edits, credentialting activities, prior authorization, utilization and quality review, , FDR education, post-processing review of claims, adequate staffing and resources to research unusual incidents, oversight of delegated FDR activities, internal monitoring and auditing and corrective action plans to assist the Health Plan in preventing and detecting potential Fraud, Waste and Abuse activities.

D. Prevention/ Detection of Member Fraud, Waste or Abuse.
   1. If the Health Plan is made aware of, or suspects, member Fraud or Abuse, (for example, an FDR reports potential or suspected member Fraud, or Abuse to the Health Plan), the Health Plan will notify the appropriate government agency.
   2. The Health Plan proactively monitors and audits services received by members to ensure members have received billed services. Services which are reported as not received by members are researched and potentially reported to the appropriate government agency.
   3. The Health Plan Compliance Department coordinates all FWA monitoring of information received from Medicare and Medicaid and facilitates the appropriate FWA steps to ensure proper monitoring for each situation.

E. Health Plan Internal Reporting of FWA.
   1. If a Health Plan employee discovers, or is made aware, that an incident of potential Fraud, Waste or Abuse has occurred, they notify their manager, director, the Health Plan Compliance Officers, make a report via the compliance hotline, "ComplyLine", send a FWA referral through the Customer Relationship Module, forward to the BUHPCompliance@bannerhealth.com mailbox, send through interoffice mail or U.S. mail, or submit via the dedicated compliance fax number 520 874 7072, immediately.
   2. If a member or FDR discovers, or is made aware, that an incident of potential Fraud, Waste or Abuse has occurred, they are to notify the Health Plan via the call center, their provider relations representative, contact the Health Plan Compliance Officers or make a report via the ComplyLine immediately.
   3. The Health Plan's Fraud, Waste and Abuse Specialist conducts a timely and reasonable inquiry into potential violations of Federal and state criminal, civil, administrative laws, rules and regulations. The inquiry must take place within 2 weeks from when the issue of non-compliance was first identified. The Fraud, Waste, and Abuse (FWA) Specialist will research the inquiry to substantiate whether violations may have occurred.

4. The Health Plan Compliance Department reports the incident to the appropriate government agency either by phone, U.S. mail, email, fax or on-line.

F. Health Plan Reporting of FWA to AHCCCS.
   1. If the Health Plan is made aware of an incident of alleged Fraud, Waste, or Abuse has occurred or is occurring, the Health Plan Compliance FWA Specialist shall report the incident to the AHCCCS-OIG within 10 calendar days. Subcontractors, Contractors, Providers, Members, Volunteers, Interns or Community Stakeholders should report potential incidents of FWA to the AHCCCS OIG directly through the website, email or telephone. This information is posted in the Compliance Program and FWA Plan. Health Plan Staff or Governing Body Members can report directly to AHCCCS OIG or to the Compliance Department, who will then report on their behalf.
   2. If the Health Plan receives information about changes in a member's circumstances that may effect the member's eligibility including changes in the member's residence or the death of the member, the Health Plan shall report the incident to the FWA Specialist or other Compliance Staff and they will promptly notify AHCCCS-OIG.
   3. To report to the AHCCCS-OIG, the Health Plan shall use the online form "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program," available on the AHCCCS-OIG website. Attached with the form, shall be all pertinent information to assist AHCCCS in its investigation process.
   4. If the Health Plan Staff, FDR, or contracted provider identifies an incident that would necessitate self-disclosure, the Health Plan Staff, FDR, or contracted provider shall report the incident within 10 calendar days to the AHCCCS-OIG by completing and submitting the "Provider Self Disclosure" form, found on the AHCCCS-OIG webpage. Attached with the form, shall be all pertinent information to assist AHCCCS in its investigation process.
   5. The Office of Inspector General (OIG) at AHCCCS handles all alleged fraud investigations. The Health Plan shall take no action to recoup or otherwise offset or act in any manner inconsistent with AHCCCS-OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, and/or impose a civil monetary penalty.
      a. If AHCCCS-OIG chooses to seek additional and/or clarifying details regarding a referral from the Health Plan, the Health Plan Compliance Staff in partnership with any other department involved, will have 30 calendar days to provide the requested documentation.
      b. The Health Plan assigns to AHCCCS the right to recoup any amounts overpaid to a provider as a result of fraud, waste, or abuse. In the event the Health Plan receives or has recovered an overpayment or receives anything of value that could be construed to represent the repayment of any amount

expended due to fraud, waste or abuse, the Health Plan applicable department will notify AHCCCS-OIG immediately and forward that recovery to AHCCCS OIG within 30 days of its receipt.

c. The AHCCCS-OIG will notify the Health Plan when the investigation has concluded and of the necessary safeguarding required with relation to the confidentiality of the case.
d. In the event that AHCCCS-OIG, either through a civil monetary penalty or assessment, a global civil settlement or judgment, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Health Plan has no claim to any portion of this recovery. These include, but are not limited to:
    i. Recovery of an overpayment,Civil monetary penalties and/or assessments,
    ii. Civil settlements and/or judgments,
    iii. Criminal restitution,
    iv. Collection by AHCCCS or indirectly on AHCCCS' behalf by the Office of the Attorney General,
    v. Other, as applicable.
e. The Health Plan assigns to AHCCCS any and all of its rights to recover overpayments due to fraud, waste, or abuse.
    i. If the AHCCCS-OIG determines that the case is not considered to be Fraud, Waste, or Abuse, the Health Plan will refer to the appropriate AHCCCS policy manuals for further action.
f. The Health Plan Staff have a responsibility to report all situations even if the issue is identified through a delegated entity.
g. If the Health Plan Staff is made aware that an incident of alleged Fraud, Waste or Abuse has occurred, the Health Plan Staff will report the incident by completing and submitting the reporting form available on the AHCCCS-OIG webpage within 10 calendar days or submitting to the Compliance Department to report.
h. The Health Plan Credentialing Department will also report to AHCCCS-OIG any credentialing denials including, but not limited to those resulting from licensure issues, quality of care concerns, excluded, terminated, or otherwise sanctioned providers, and those which are the result of alleged Fraud, Waste, or Abuse.

G. Health Plan Reporting to Medicare.
1. For instances involving Part C and Part D potential Fraud, Waste and Abuse, the Health Plan Compliance Department forwards referrals to the MEDIC for further investigation and/or potential referral to law enforcement or regulatory agencies

as required by law within 30 days after the determination that a violation may have occurred.

a. If the Compliance Officers, Fraud, Waste, and Abuse Specialists or other Compliance Department Staff does not have the resources to research the potential issue of Fraud, Waste, or Abuse in a timely manner, the matter will be referred to the NBI MEDIC within 30 days of the date the potential fraud or abuse is identified so that the potentially fraudulent or abusive activity does not continue.
b. Reports to MEDIC are done by completing and returning the appropriate complaint form via email, fax, or U.S. Mail to the NBI MEDIC.
c. The Health Plan prepares a referral package that includes, to the extent available, the following:
d. FDR name, all known billing and tax identification numbers, and addresses;
e. Type of FDR involved in the allegation and the perpetrator, if an employee of the FDR;
f. Type of item or service involved in the allegation;
g. Place of service;
h. Nature of the allegation(s);
i. Timeframe of the allegation(s);
j. Narration of the steps taken, and information uncovered during the Health Plan's screening process;
k. Date of Part D service, drug code(s);
l. Date of Part C service, service code(s);
m. Member name, member Health Insurance Claim number, address and telephone number;
n. Name and telephone number of Health Plan employee, agent or contractor who received the complaint;
o. Contact information of the complainant, if not the member;
p. All documents pertaining to prior sanctions and/or compliance history and corrective actions taken, if any.

2. MEDIC has the right to request additional information, so the matter can be resolved. If the MEDIC requests additional information, Health Plan Compliance Staff furnishes the requested information within 30 days, unless the MEDIC specifies otherwise, or the member's health is at risk.
3. Health Plan Compliance Staff continue to track all aspects of the case and provides updates to the MEDIC when new information regarding the matter is identified.
4. Health Plan Staff have a responsibility to report all situations even if the issue is identified through a delegated FDR. Health Plan Staff can report to the Compliance Department who will then report to MEDIC or have the option of reporting directly and then informing Compliance.

5. MEDIC will investigate the referrals from the Health Plan, develop the investigations and make referrals to appropriate law enforcement agencies or other outside entities when necessary.
6. If MEDIC determines a referral to be a matter related to non-compliance or mere error rather than Fraud, Waste or Abuse, it will be returned to CMS and/or the Health Plans for appropriate follow-up.

H. The Health Plan is required to research potential overpayments identified by Medicare or the OIG. If after the research is completed and actions are warranted, the Health Plan Compliance Staff attempts to recover any overpayments identified by submitting the request to the applicable department to process. The Health Plan advises Medicare and/or the OIG of the actions taken and the final disposition of the potential overpayment.

I. FDR contracts contain Fraud, Waste and Abuse clauses.

J. FWA Training Requirements.
1. The Health Plan takes every opportunity to educate FDRs, FDR employees and Health Plan employees on preventing, identifying, and reporting Fraud, Waste and Abuse and the False Claims Act as outlined in Health Plan policy & procedure CP 5019 FWA FDR Awareness and CP 5020 Employee FWA Awareness.
2. All Health Plan FDRs are required to complete a General Compliance and FWA training within 90 days of hire and annually thereafter.
3. All Health Plan employees, temporary employees, interns, volunteers and Governing Body members are required to complete the Banner Health required Compliance training which includes information on Code of Conduct and FWA within 60 days of hire and annually thereafter. (Note: during National/State emergencies due dates were extended to 120 days for new employees).
4. Health Plan Employees will complete FWA training through web-based training on the Banner Learning Center System.
    a. Records of training completion will be maintained for 10 years.
5. FDRs contracted with the Medicare Program will complete training using the training provided by Health Plan or a comparable training.
    a. FDRs are to maintain training records for 10 years.
6. FDRs contracted with AHCCCS will complete training/education through their receipt of the Provider Manual and materials on the website.
    a. Additional FWA and Compliance training will be provided to AHCCCS contracted providers through Provider Education meetings organized by Provider Relations Staff.

b. Provider Relations Staff will track receipt of manuals, if provided in person, as well as track communication to providers via fax or email, and other provider education and maintain records for 10 years.

7. Health Plan members are to be educated on FWA including, but not limited to member newsletters, the Member Handbook, Claims verification, annual distribution of the Notice of Privacy Practice, and other member outreach and education efforts.

V. Performance and Outcome Measures:

A. 100% of suspected Fraud, Waste and Abuse allegations will be properly reported, researched, documented and tracked.

VI. References:

A. Medicare.gov website – Forms, Help & Resources/Report Fraud and Abuse
B. A.R.S. Title 36, Chapter 29, Article 1, 36-2918.01
C. 42 C.F.R. 455.2
D. Chapter 9 Prescription Drug Benefit Manual, Chapter 21 Medicare Managed Care Manual, Section 50.3.2
E. AHCCCS Contractor Operations Manual – Chapter 100; 103 Fraud and Abuse Policy
F. AHCCCS Contractor Operations Manual – Chapter 400; 424 Verification of Receipt of Paid Services Policy
G. AHCCCS Complete Care Contract; Paragraph 58 – Corporate Compliance
H. AHCCCS EPD ALTCS Contract; Paragraph 64 – Corporate Compliance
I. Desktop Procedure, Reporting to FWA to NBI MEDIC
J. Desktop Procedure, Reporting FWA to AHCCCS

VII. Related Policies/Procedures:

A. Health Plan Policy – ND 5003 Provider Notification and Communication Methods
B. Health Plan Policy – ND 5002 New Provider Orientation
C. Health Plan Policy – ND 1112 A; Provider Office Visits
D. Health Plan Policy – CP 5227 Monitoring and Auditing
E. Health Plan Policy – CP 5019; FWA FDR Awareness
F. Health Plan Policy – CP 5020; FWA Employee Awareness

VIII. Keywords and Keyword Phrases:

A. Fraud, Waste and Abuse
B. Training
C. NBI MEDIC
D. AHCCCS OIG