Fraud, Waste and Abuse

A Presentation for Network Providers

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Delivering the Next
Generation
of Health Care

Presentation Topics

Our Pledge

Keystone First – CHIP (referred to hereafter as “the Plan”) is dedicated to reducing and possibly eliminating incidences of fraud, waste and abuse from its programs and cooperates in fraud, waste and abuse investigations conducted by state and/or federal agencies, including:

- The Medicaid Fraud Control Section of the Pennsylvania Attorney General’s Office.
- The Federal Bureau of Investigation.
- The Drug Enforcement Administration.
- The HHS Office of Inspector General.
- Bureau of Program Integrity of DHS.
- Governor’s Office of the Budget.
- The Pennsylvania State Inspector General.
- CMS.
- The United States Attorney’s Office/Justice Department.

Program Integrity Special Investigations Unit

Keystone First – CHIP has its own Special Investigations Unit (SIU) within the Program Integrity Division.

It is the policy of Program Integrity – SIU:

- To review and investigate all allegations of fraud, waste and abuse;
- To take corrective actions for any supported allegations after a thorough investigation; and
- To report confirmed misconduct to the appropriate parties and/or agencies.

THE LAW

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The Law

Under the CHIP program, the Plan receives state and federal funding for payment of services provided to our Enrollees.

In accepting Claims payment from the Plan, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud, waste or abuse against the program.

False Claims Act (FCA)

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval.

The FCA also 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.

The Plan must certify that claims data presented to the government for payment is accurate to the best of its knowledge.

The FCA encourages whistleblowers to come forward by providing protection from retaliation. Penalties for violating the FCA could include a minimum $13,508 to $27,018 fine per false claim, imprisonment, or both, and possible exclusion from federal government health care programs.

The Fraud Enforcement and Recovery Act of 2009 (FERA)

Passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA).

Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:

- Expands potential liability under the FCA for government contractors.
- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor.
- Expands the definition of false record to include any record that is material to a false/fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

DEFINITIONS

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What is Fraud?

Fraud – Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the CHIP-MCO, a subcontractor, a Provider, or an Enrollee, among others.

What is Waste?

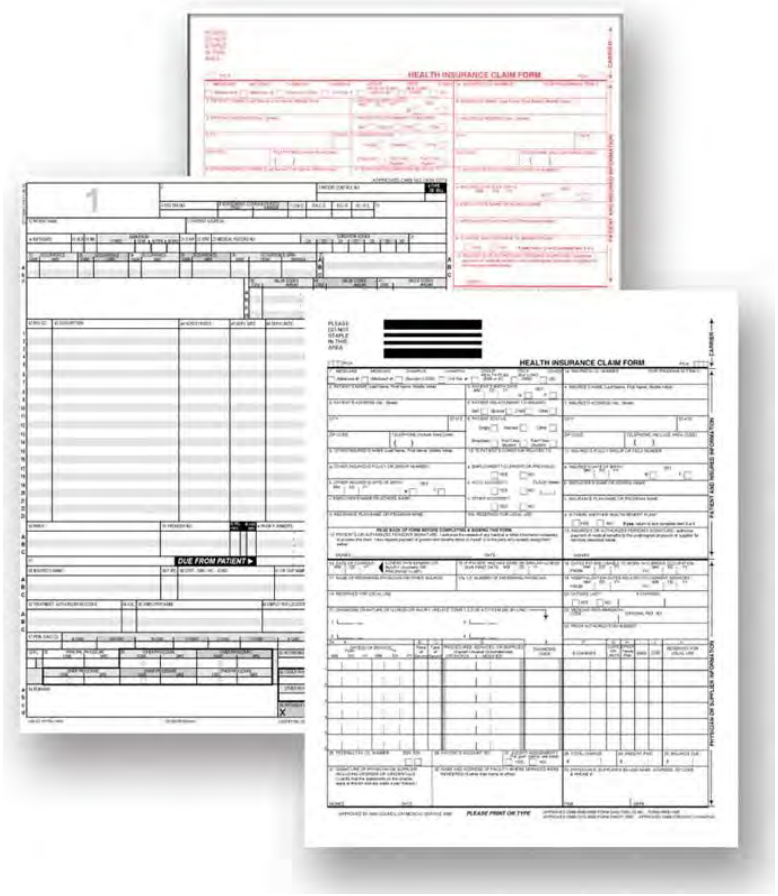
Waste – The overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather misuse of resources.

What is Abuse?

Abuse – Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to CHIP, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or agreement obligations (including the RFA, Agreement, and the requirements of state law or federal regulations) for health care in a managed care setting. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider or entity has not knowingly or intentionally misrepresented facts to obtain payment. The Abuse can be committed by the CHIP-MCO, Subcontractor, Provider, State employee, or an Enrollee, among others.

Abuse also includes Enrollee practices that result in unnecessary cost to CHIP, the CHIP-MCO, a Subcontractor, or Provider.

WASTE AND RECOVERY



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Some examples of Waste include:

- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/procedure codes, retro TPL/Eligibility.

Waste Recoveries

The Payment Integrity Department of Keystone First – CHIP is responsible for identifying and recovering claim overpayments. The Department performs several operational activities to ensure the accuracy of Providers' billing submissions.

The Department utilizes internal and external resources to prevent the payment of claims associated with waste and to initiate recovery when overpaid claims are identified.

As a result of these claims accuracy efforts, Providers may receive letters from the Plan, or on behalf of the Plan, regarding recovery of potential overpayments and/or requesting medical records for review.

Any questions should be referred to the contact information provided in the letter to expedite a response to questions or concerns.

Returning Improper or Over Payments

Call Keystone First – CHIP's Provider Services Department at **1-800-521-6007**

There are two ways to return overpayments to the Plan:

1. Have the Plan deduct the overpayment/improper payment amount from future claims payments,
2. Return the overpayments directly to the plan via:
   - Use the Provider Claim Refund form available on the Provider Center at www.keystonefirstchip.com under Forms.
   - Mail the completed form and refund check for the overpayment/improper payment amount to:

Attention: Provider Refunds

Keystone First – CHIP

P.O. Box 21152

Eagan, MN 55121

Returning Improper or Over Payments for Dental Providers

Contact Dental Provider Services at **1-855-343-7401**.

Provider Self-Audit Protocol

Providers may also follow the “Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol” to return improper payments or overpayments. Access the DHS voluntary protocol process via the following web address:

https://www.pa.gov/agencies/dhs/report-fraud/medicaid-provider-self-audit-protocol.html

RECIPIENT FRAUD

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Defining Recipient Fraud

Someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, **medical assistance**, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS card, trafficking SNAP benefits or taking advantage of the system in any way.

PROVIDER FRAUD

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Examples of Provider Fraud:

- Billing for services not rendered or not Medically Necessary.
- Submitting false information to obtain authorization to furnish services or items to CHIP Enrollees.
- Prescribing items or referring services which are not Medically Necessary.
- Misrepresenting the services rendered.
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare, Medicaid or any other federal health care program.
- Retaining funds that were improperly paid.
- Billing Enrollees for covered services inappropriately.
- Failure to perform services required under a capitated contractual arrangement.
- Up-coding to more expensive service than was rendered; billing for more time or units of service than provided.

EMPLOYEE SCREENING REQUIREMENTS

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Required Employee Screening for Exclusion from Federal Programs

As required by the Department of Human Services' Office of Inspector General (HHS-OIG) 42 CFR Section 455.436 and outlined in the Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletin 99-11-05, all Providers who participate in Medicare, Medicaid or any other federal health care program are required to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in any of the aforementioned programs.

Employees should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search.

Required Employee Screening for Exclusion from Federal Programs

Examples of individuals or entities that Providers must screen for exclusion include, but are not limited to:

- Individual or entity who provides a service for which a claim is submitted to CHIP;
- Individual or entity who causes a claim to be generated to CHIP;
- Individual or entity whose income derives all, or in part, directly or indirectly, from CHIP funds;
- Independent contractors if they are billing for CHIP services;
- Referral sources, such as Providers who send a CHIP Enrollee to another Provider for additional services or second opinion related to medical condition.

Required Employee Screening for Exclusion from Federal Programs

The Pennsylvania Department of Human Services and Keystone First – CHIP are prohibited from paying for any items or services furnished, ordered, or prescribed by individuals or entities excluded from the Program as well as other federal health care programs.

REPORTING FRAUD

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Reporting Fraud Waste and/or Abuse to the Plan

- **Phone** the toll-free Provider Compliance Hotline at **1-866-833-9718**;
- **E-mailing** to fraudtip@amerihealthcaritas.com; or,
- **Mailing** a written statement to:

Special Investigations Unit:

Keystone First – CHIP

3875 West Chester Pike

Newtown Square, PA 19073

Reports may be made anonymously.

Information that will Assist the Plan with an Investigation

- Contact Information (e.g., name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Reporting Fraud Waste and/or Abuse to the Commonwealth

Phone: 1-844-DHS-TIPS or 1-844-347-8477

On-line: https://www.pa.gov/agencies/dhs/report-fraud/medicaid-fraud-abuse.html

Fax: 1-717-772-4655, Attn: MA Provider Compliance Hotline

Mail:

Department of Human Services

Office of Administration

Bureau of Program Integrity

P.O. Box 2675

Harrisburg, PA 17105-2675

RESOURCES

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Resources

Medical Assistance Manual-Provider Prohibited Acts: www.pacode.com/secure/data/055/partIIItoc.html (see§1101.75)

See Pennsylvania Department of Human Services (DHS) Medical Assistance Bulletin 99-11-05 at https://www.pa.gov/agencies/dhs.html

To search the List of Excluded Individuals/Entities (LEIE) database, please access: https://oig.hhs.gov/exclusions/index.asp

The Pennsylvania Department of Human Services' Medicheck List of Precluded Providers may be accessed here: https://www.pa.gov/agencies/dhs/report-fraud/medicheck-list.html

Access the Electronic Code of Federal Regulations (42 CFR §455.436) here: https://www.ecfr.gov/

The System for Award Management (SAM) is an official website of the U.S. government. Search for entity registration and exclusion records https://sam.gov/content/home

Attestation

Thank you for completing the Fraud, Waste and Abuse Training. Please remember to complete the training attestation.

https://www.surveymonkey.com/r/G5GY23M

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