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Special Investigations Unit Fraud, Waste & Abuse Review & Recovery Policy

PURPOSE

The purpose of this policy is to discuss the Special Investigations Unit (SIU)'s role in investigating instances of potential FWA, the process for conducting reviews and reporting cases to outside regulatory authorities when necessary.

POLICY

The SIU is dedicated to detecting, investigating, preventing, and recovering the loss of corporate and customer assets resulting from fraudulent and abusive action committed by providers, members, and employees.

The SIU is committed to providing assurances that VillageCareMAX (VCMAX) complies with the State and Federal dollars that fund our program. This commitment requires that we ensure that health care services provided to eligible members are done so by providers entitled to participate in federal programs, are medically necessary, meet certain quality requirements, are provided in a cost-effective manner, are billed appropriately and paid according to contract terms and VCMAX policies.

To that end, VCMAX, in the course of normal operations, works to prevent fraud, waste and abuse (FWA) and to detect and correct any instances of FWA, whether member, provider, employee, or vendor/ contractor-related.

DEFINITIONS

Fraud - is defined as the intentional misrepresentation of an important fact submitted on, or in support

of, a healthcare claim, or application for healthcare coverage, for the purpose of obtaining something, to which you (or someone else) is not entitled.

Abuse - is defined as any practice that is inconsistent with sound fiscal, business or medical practices and results in unnecessary cost to the state, federal government or health insurer, in in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of medical practice.

Examples of Fraud and Abuse include, but are not limited to the following:

Providers

1. Billing for services not rendered;
2. Deliberately filing incorrect diagnosis or procedure codes to maximize payment;
3. Misrepresenting services or dates of service;
4. Billing for non-covered services or dates of service;
5. An eligible provider billing for services provided by a non-eligible provider or individual;
6. Accepting or offering kickbacks and bribery;
7. Billing for “free” services

Members

1. Loaning an identification card for use by another person;
2. Enrolling someone not eligible for coverage under their policy or group coverage;
3. Altering the amount or date of service on a claim form or prescription receipt;
4. Altering the amount of date of service on a claim form or prescription receipt

PROCEDURE

A. Special Investigation Unit's Process

The SIU’s mission is to detect, investigate, prevent and recover the loss of corporate and customer assets resulting from fraudulent and abusive action committed by providers, members, groups, brokers, or others. They may also recommend referring individuals/entities that have been found to have potentially committed fraud to law enforcement agencies for potential prosecution. The SIU investigation process may include, but is not limited to, review and analysis of claims data for member services, correspondence, bills, benefit statements, financial records, utilization management, billing patterns, claims history, query sanctions, disciplinary issues, court records, and insurance activities related to the provider, and interviews with persons with information relating to suspected fraud or abuse.

The SIU reviews all identified and reported issues to determine the validity and severity of the potential case and the extent of any further investigation. Investigations are conducted based on the nature and potential severity of the issue cited, rather than by order of the reports received.

Once the SIU decides to open an investigation, the following procedures are followed:

1. The SIU sends an acknowledgement to the source of the report, if applicable, and known. If the source is internal, the acknowledgement can be sent in the form of an internal e-mail.
2. The SIU researches the issue and may contact relevant parties to gather information to determine the validity of the report/referral. Research may include, but not be limited to, reviews of provider and member claims history, review of billing and/or payment history or pattern, review of prescribing/ordering history, review of medical records, on-site review or monitoring of a provider's office, interviews with providers and/or members and review of provider and/or member contracts.
3. Relative parties may include members to get a better understanding of the situation. For example, they may contact a member to ask about a visit with his or her physician. They may ask the member to describe the services provided and by whom, etc.
4. They may request medical, dental, or pharmacy records. This is done to validate that the records support the services billed. It's important that the provider submits all records requested in a timely manner in order to make a fair and appropriate assessment.
5. If overpayments or inappropriate payments are identified during the Investigation, including data-mining claims, every effort will be made to recover the full overpayment. In some cases, the SIU may negotiate a settlement with a provider to recover a portion of the overpayment or inappropriate payment. In other instances, a provider will be able to repay over a period. All adjustments will be reflected at the claim and encounter level. For providers who agree to pay over a period, a negative balance will be setup within the claims system and future claims payments would be applied to the negative balance.

B. Referrals to Outside Regulatory Authorities

From time to time the SIU may make a referral to a separate regulatory entity outside of the company if they believe Fraud is present. These referrals can be made to any of the following:

- The Centers for Medicare and Medicaid Services (CMS)
- Medicare Drug Integrity Contractors (MEDIC)
- Office of Inspector General (OIG)
- Office of Medicaid Inspector General (OMIG)
- Office of Attorney General Medicaid Fraud Control Unit (MFCU)

Approval Signatures

Step Description	Approver	Date
Final Approval	Emma Devito: President & CEO	1/26/2023

Compliance Officer	Dara Quinn: Chief Compliance Officer	1/26/2023
	Shané Abercrombia: Director of Compliance	12/15/2022