

Governing Body:		Pages: 10
<b>Mid-Valley Behavioral Care Network (MVBCN)</b>		Date: 09/17/2007
Subject:	Prepared By:	Approved By:
<b>Prevention and Detection of Fraud and Abuse</b>	MVBCN Operations Coordinator and Executive Manager	Kellie Skenandore, Addictions and Mental Health Division, DHS

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PURPOSE AND APPLICABILITY

This policy and procedure document identifies the responsibilities of MVBCN and its sub-contractors with respect to the prevention and detection of Fraud and Abuse related to the Oregon Health Plan (OHP). MVBCN must fully comply with federal and state laws and rules that relate to the prevention and detection of fraud and abuse. MVBCN sub-contractors, consisting of Participating Providers and the Local Mental Health Authorities (LMHAs) in MVBCN’s Service Area, must also fully comply with these federal and state laws. These policies and procedures will be reviewed annually and revised as necessary.

MVBCN shall follow this policy as it applies to the OHP mental health (MH) services governed by the Mental Health Organization (MHO) Agreement between the State of Oregon and MVBCN. MVBCN has delegated responsibility to each LMHA the management of non-inpatient MH services for MVBCN OHP Members in the LMHA’s county. The LMHAs and Participating Providers shall follow the applicable sections of this policy to the extent that it applies to the MH services that they manage under delegation from MVBCN and/or provide to MVBCN OHP Members.

*This policy does not apply to chemical dependency providers (CD) credentialed by MVBCN. CD providers must follow the policy and procedure requirements of the Fully Capitated Health Plan (FCHP) whose OHP Members receive services from the CD provider.*

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## DEFINITIONS

Certain key terms used in this policy are defined below. For any term not listed below, the definition in Exhibit K of the most current MHO Agreement shall apply.

1. **ABUSE:** Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to MVBCN or the Division of Medical Assistance Programs (DMAP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes OHP Member or Recipient practices that result in unnecessary cost to MVBCN or DMAP. *OAR 410-120-0000 (2) and 42 CFR 455.2.*
2. **ADDICTIONS AND MENTAL HEALTH DIVISION (AMH):** The Oregon Department of Human Services (DHS) office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.
3. **DIVISION OF MEDICAL ASSISTANCE PROGRAMS (DMAP):** A Division within the DHS; DMAP is responsible for coordinating the medical assistance programs within the State of Oregon including the OHP Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs. *OAR 410-120-0000 (55).*
4. **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 applicable federal or state law. *OAR 410-120-0000 (68) and 42 CFR 455.2.*
5. **MEDICAID:** A federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by DHS. *OAR 410-120-0000 (96).* In this policy, Medicaid is also referred to as the Oregon Health Plan.
6. **OHP MEMBER:** An individual found eligible by a program of DHS to receive health care services under the OHP Medicaid Demonstration Project or State Children's Health Insurance Program and who, for purposes of this policy, is enrolled with MVBCN.
7. **OHP MEMBER REPRESENTATIVE:** A person who can make OHP related decisions for an OHP Member who is not able to make such decisions him-/herself. OHP Member Representative may be, in the following order of priority, a person who is designated as OHP Member's health care representative, a court-appointed guardian, a spouse, or other family member as designated by OHP Member, the Individual Service Plan Team (for OHP Members with developmental disabilities), a DHS case manager, or other DHS designee. For OHP Members in the care or custody of DHS's Children, Adults and Families Division or the Oregon Youth Authority (OYA), OHP Member Representative is DHS or OYA. For OHP Members placed by DHS through a Voluntary Placement Agreement (CF Form 499), OHP Member shall be represented by his or her parent or legal guardian.
8. **PARTICIPATING PROVIDER:** An individual, facility, corporate entity, or other organization credentialed by MVBCN as a Provider of non-inpatient MH services and approved by MVBCN's Board of Directors as a sub-contractor to provide MH services to MVBCN OHP Members. Participating Providers must enter into a formal contract with MVBCN and agree to bill and/or submit encounter data in accordance with that contract.

9. PERSON: Any natural person, partnership, corporation, association, or other legal entity, including any state or political subdivision of a state. *31 USC 3729-3733*.
10. PROVIDER: An organization, agency or individual licensed, certified and/or authorized by law to render professional health services to OHP Members.
11. RECIPIENT: A person who is currently eligible for medical assistance. *OAR 410-120-0000 (154)*. In this policy, a Recipient who is assigned to MVBCN for MH services is an OHP Member.

## POLICY AND PROCEDURE

### **I. Fraud and Abuse Laws: Liabilities and Penalties**

A. *MVBCN and each LMHA and Participating Provider are subject to the following laws and rules that relate to fraud and abuse involving Medicaid funds:*

1. Federal False Claims Act (31 USC 3729-3733): This law provides for penalties and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims for government funds, such as Medicaid funds. Under this law's *quid tam* provisions, an individual with evidence of fraud, also known as a "whistleblower", is authorized to file a case in federal court and sue, on behalf of the federal, the Persons or entities engaged in the fraud and to share in any money that the government may recover.
2. Federal administrative remedies for false claims and statements (31 USC 3801-3812): Known as the Program Fraud Civil Remedies Act, under this law, anyone who makes, presents or submits (or causes to be made, presented or submitted) a claim to the federal government, such as for Medicaid funds, that the person knows or has reason to know is false, fictitious or fraudulent, or that omits a material fact, is subject to a penalty of up to \$5,000 per claim, plus an assessment of up to twice the amount of each false or fraudulent claim. The United States Inspector General investigates violations of this law. Enforcement can begin with a hearing before an administrative law judge. The government can recover penalties by a lawsuit or through an administrative offset against "clean" claims.
3. Federal Regulation 42 CFR Subpart A 455.12 – 455.106 Medicaid Agency Fraud Detection and Investigation Program, which defines the responsibilities of the state agency
4. Oregon laws pertaining to civil or criminal penalties for false claims and statements:
  - a) ORS 411.670 to 411.690 (submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery);
  - b) ORS 646.505 to 646.656 (unlawful trade practices);
  - c) ORS chapter 162 (crimes related to perjury, false swearing and unsworn falsification);
  - d) ORS chapter 164 (crimes related to theft);
  - e) ORS chapter 165 (crimes involving fraud or deception), including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments);
  - f) ORS 166.715 to 166.735 (racketeering – civil or criminal);
  - g) ORS 659A.200 to 659A.224 (whistleblowing);

- h) ORS 659A.230 to 659A.233 (whistleblowing);
  - i) OAR 410-120-1395 to 410-120-1510 (DMAP program integrity, sanctions, fraud and abuse); and
  - j) Common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.
5. MVBCN, the LMHA and Participating Provider may be subject to other fraud and abuse laws not identified above.

## **II. Fraud and Abuse Laws: “Whistleblower” Protections**

*A. Individuals employed by MVBCN, an LMHA or Participating Provider who come forward with evidence of fraud and abuse involving Medicaid funds have the following legal protections:*

1. Federal False Claims Act (31 USC 3729-3733): Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.
2. Oregon Whistleblower Law (ORS 659A.200-224): In brief, it is an unlawful employment practice for any public employer to:
  - a) Prohibit any employee from disclosing, or take or threaten to take disciplinary action against an employee for the disclosure of, any information that the employee reasonably believes is evidence of:
    - i. A violation of any federal or state law, rule or regulation by the state, agency or political subdivision; or
    - ii. Mismanagement, gross waste of funds or abuse of authority or substantial and specific danger to public health and safety resulting from action of the state, agency or political subdivision; or
    - iii. The fact that a person receiving services, benefits or assistance from the state or agency or subdivision, is subject to a felony or misdemeanor warrant for arrest.
  - b) Require any employee to give notice prior to making any disclosure or engaging in discussion described in Section II (A)(2)(a)(i-iii).
  - c) Discourage, restrain, dissuade, coerce, prevent or otherwise interfere with disclosure or discussions described in Section II (A)(2)(a)(i-iii).
3. Oregon law pertaining to an employee initiating or aiding in a legal proceeding (ORS 659A.230-233): In brief, it is an unlawful employment practice for an employer to discharge, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported

criminal activity by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

4. Individuals may have other legal protections not identified above.

### **III. Preventing and Detecting Fraud and Abuse**

*A. Participating Provider shall develop and implement a program to prevent and detect fraud and abuse that includes, at a minimum, the following elements:*

1. Credentialing of employed and sub-contracted Providers in accordance with MVBCN's credentialing policy. Elements of MVBCN's credentialing policy relating to fraud and abuse include:
  - a) Provider self-disclosure of adverse actions relating to Medicaid and Medicare provider status, and suspected or verified fraud and/or abuse involving Medicaid funds;
  - b) Criminal background checks; and
  - c) Exclusion of persons described in Subsection *D* below.
2. Requiring employees and contractors to disclose any conflict of interest relating to the provision of and payment for OHP services.
3. Disciplinary guidelines for employees and sub-contracted Providers whose actions constitute fraud or abuse.
4. Formal Complaint and Appeal procedures for OHP Members and OHP Member Representatives.
5. Periodic auditing of a random sample of Provider clinical records and the corresponding billing and claims payment data.
6. Procedures to promptly repay Medicaid funds paid in error to the appropriate LMHA in MVBCN's Service Area, and to correct the corresponding billing data.
7. Appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, appointment schedules, eligibility data, and related resources that may be used to facilitate fraud or abuse.

*B. With respect to the contractual responsibility of the LMHAs to manage their local non-inpatient MH service delivery systems, each LMHA shall develop and implement a program to prevent and detect fraud and abuse that includes, at a minimum, the following elements:*

1. Credentialing of out-of-panel Providers in accordance with MVBCN's credentialing policy.
2. Requiring employees and contractors to disclose any conflict of interest relating to the provision of and payment for OHP services.
3. Disciplinary guidelines for employees and contractors whose actions constitute fraud or abuse.
4. Formal Complaint and Appeal procedures for OHP Members and OHP Member Representatives.
5. Complaint and appeal procedures for Providers.

6. Periodic auditing of a random sample of Provider clinical records and the corresponding billing and claims payment data.
  7. Regular monitoring of Provider billing and claims submission activity for patterns and anomalies that may indicate fraud or abuse.
  8. Appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, eligibility data, and related resources that may be used to facilitate fraud or abuse.
  9. Procedures to request and process repayment from Participating Providers and out-of-panel Providers for Medicaid funds paid in error, and to adjust the corresponding claims payment data.
  10. Procedures for employees and contractors of Participating Providers and out-of-panel Providers to report cases of *suspected* fraud or abuse involving Medicaid funds to the LMHA.
    - a) Participating Providers and out-of-panel Providers are encouraged to report cases of suspected fraud or abuse to the LMHA for their county. However, if there is reason to believe that the LMHA cannot respond appropriately to the suspected case, or if the case involves the LMHA, then the case should be reported to MVBCN.
  11. Procedures for the LMHA to report cases of *probable or confirmed* fraud or abuse involving Medicaid funds to MVBCN for further investigation, corrective action and/or referral to the Medicaid Fraud Control Unit (MFCU).
 

1515 SW 5<sup>TH</sup> Avenue, Suite 410  
Portland, Oregon 97201  
Phone: (971) 673-1880, Fax: (971) 673-1890
  12. Procedures for the LMHA to report cases of *suspected or verified* fraud or abuse by an OHP Member to MVBCN for further investigation, corrective action and/or referral to the DHS Fraud Investigation Unit
 

P.O. Box 14150  
Salem, Oregon 97309-5027  
Phone: (503) 378-6826, Fax: (503) 373-1525
- C. *With respect to MVBCN's responsibility to centrally manage inpatient and other MH services for which funds are not sub-capitated to the LMHAs, MVBCN shall develop and implement a program to prevent and detect fraud and abuse that includes the following elements:*
1. Credentialing of out-of-panel Providers in accordance with MVBCN's credentialing policy.
  2. Requiring employees and contractors to disclose any conflict of interest relating to the provision of and payment for OHP services.
  3. Disciplinary guidelines for employees and contractors whose actions constitute fraud or abuse.
  4. Formal Complaint and Appeal procedures for OHP Members and OHP Member Representatives.
  5. Complaint and appeal procedures for Providers.

6. Regular monitoring of Provider billing and claims submission activity for patterns and anomalies that may indicate fraud or abuse.
7. Appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, eligibility data, and related resources that may be used to facilitate fraud or abuse.
8. Procedures to request and process repayment from Providers for Medicaid funds paid in error, and to adjust the corresponding claims payment data.
9. Procedures for employees and contractors of MVBCN and Providers to report cases of suspected fraud or abuse involving Medicaid funds to MVBCN.

*D. MVBCN, LMHAs and other Participating Providers shall assure the exclusion of certain persons as follows:*

1. Persons who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549, or under guidelines implementing such order;
2. Persons who are currently excluded from participation in Medicaid programs under Section 1128 or 1128A of the Social Security Act.
3. MVBCN, LMHAs and other Participating Providers shall not:
  - a) Refer OHP Members to such persons described above, nor accept billings for services for OHP Members from such persons; or,
  - b) Knowingly have a person described above as a director, officer, partner, or owner of more than 5% of the entity's equity; or,
  - c) Have an employment, consulting, or other agreement with a person described above for the provision of items and services that are significant and material to the entity's obligations under any agreement to provide OHP services.

#### **IV. Training and Education**

*A. MVBCN and each LMHA and Participating Provider shall train its employees and contractors regarding MVBCN's policy to prevent and detect fraud and abuse involving Medicaid funds and provide, in that training and in writing for inclusion in the employee handbook materials, at a minimum, the following:*

1. Articulation of the organization's commitment to guard against fraud and abuse.
2. Articulation of the organization's obligation to adhere to MVBCN's policy.
3. Description of federal and state laws relating to personal liability for knowingly engaging in actions that may constitute fraud or abuse.
4. Discussion of an employee's rights as a "whistleblower" to be protected from retaliation by his/her employer for coming forward with information about fraud or abuse.
5. Description of the organization's program to prevent and detect fraud and abuse, including discussion of disciplinary guidelines for actions that constitute fraud or abuse.
6. Procedures to report fraud or abuse to the LMHA and/or MVBCN.
7. DHS and over health oversight entities are not limited in their authority to pursue legal redress for fraud and abuse to the full extent of the law.

## **V. Compliance Officers; Compliance Committee**

### *A. Compliance Officers*

1. MVBCN and each LMHA shall designate an individual as the Fraud and Abuse Compliance Officer who is accountable to the organization's senior management. Responsibilities of the Compliance Officer include, but are not limited to, the following:
  - a) To receive training on, and maintain current knowledge of, the federal and state laws and regulations regarding fraud and abuse;
  - b) Establishing and implementing a clear and accessible process for any individual to bring concerns or evidence of fraud or abuse to the attention of the Compliance Officer;
  - c) Ensuring compliance with the organization's program to prevent and detect fraud and abuse, including publicizing the disciplinary consequences of participation in fraud or abuse;
  - d) Disseminating written information, such as that described in Section IV above; and providing guidance to employees and contractors about the program;
  - e) Participating in training and resource development activities with other Compliance Officers;
  - f) Maintaining records of cases reported to the organization and submitting any required reports to MVBCN; and
  - g) Serving as the point of contact for cases referred to MVBCN and/or the MFCU.

### *B. Compliance Committee*

1. A Compliance Committee shall be formed that consists of the Compliance Officers from the LMHAs, the Compliance Officer from MVBCN, a representative from MVBCN's third party administrator, and other individuals as directed by MVBCN senior management.
  - a) The Committee shall meet on a regular basis to discuss and review cases reported to the LMHAs and/or MVBCN in order to make recommendations to MVBCN senior management about technical assistance, process improvements, and/or corrective actions necessary for MVBCN and its sub-contractors, including specific Participating Providers, to fully comply with federal and state laws and/or to meet their contractual responsibilities.

## **VI. Enforcement; Corrective Action**

- A. *With respect to MVBCN's responsibility to ensure compliance with federal and state laws and rules to prevent and detect fraud and abuse, MVBCN shall develop and implement an enforcement program that includes the following elements:*
  1. Procedures to receive, and promptly investigate and respond to cases of suspected or verified fraud or abuse reported to MVBCN.
  2. Procedures to refer cases of suspected or verified fraud or abuse to the Medicaid Fraud Control Unit and to notify the DHS Addictions and Mental Health Division of MFCU referrals.

- a) Examples of cases that should be referred to MFCU include:
  - i. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical records;
  - ii. Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher level procedure code than is documented in the clinical records;
  - iii. Any verified case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring compliance rating or collecting Medicaid payments not otherwise due;
  - iv. Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to OHP Members;
  - v. Providers who intentionally fail to render medically appropriate covered services to OHP Members;
  - vi. Providers who knowingly charge OHP Members for services that are covered or intentionally balance bill an OHP Member the difference between the service charge and the payment from MVBCN or the LMHA, in violation of DHS rules;
  - vii. Any case of theft, embezzlement or misappropriation of Medicaid (Title XIX) or SCHIP (Title XXI) program money.
- b) Notification to AMH of referrals to MFCU shall include the following information:
  - i. Provider's name, Oregon Medicaid provider number and address;
  - ii. Type of Provider;
  - iii. Source of complaint;
  - iv. Nature of complaint;
  - v. Approximate range of dollars involved;
  - vi. Disposition of complaint when known; and
  - vii. Number of complaints for the time period.
- 3. Procedures to ensure that MVBCN does not notify or otherwise advise a sub-contractor of an MFCU or DHS fraud investigation so as not to compromise the investigation.

*B. MVBCN senior management may determine that it is necessary for a sub-contractor to undertake corrective action in order to fully comply with laws and rules to prevent and detect fraud and abuse and/or to meet their contractual responsibilities.*

- 1. Corrective action procedures shall proceed according to the section in the sub-contractor's contract titled *Termination for Cause*, as follows:
  - a) If a sub-contractor fails to perform any of its obligations under the contract, within the time and in the manner provided, or otherwise violates any of the terms of the contract or applicable federal, state, and local statutes and rules, MVBCN shall either:

- i. Provide an opportunity for the sub-contractor to cure the breach within ten (10) business days. If MVBCN determines that the sub-contractor's efforts to cure the breach within this timeframe are insufficient or ineffective, MVBCN shall seek to cure the breach in accordance with the contract attachment titled *Holding Ourselves Accountable*. If the sub-contractor has not cured the breach upon conclusion of the technical assistance and corrective action described in *Holding Ourselves Accountable*, MVBCN shall recommend to its Board of Directors termination of the sub-contractor's contract. The contract shall then terminate thirty (30) days from the date of the Board's acceptance of the recommendation for contract termination; or
- ii. Permit the sub-contractor to terminate the contract with thirty (30) days written notice.

## **VII. Access to Records; Cooperation with Activities**

A. *Sub-contractors shall provide access to records and cooperate with activities consistent with the following contract sections:*

1. Attachment H, Recordkeeping – Government Access to Records: The sub-contractor shall provide the Centers for Medicare and Medicaid Services (CMS), the Comptroller General of the United States, the Oregon Secretary of State, the Oregon Department of Justice Medicaid Fraud Control Unit, DHS and all their duly authorized representatives the right of access to facilities and to financial (including all accompanying billing records), clinical, and personnel records and other books, documents, papers, plans and writings of the sub-contractor, or its contracted Providers and other contractors, that are pertinent to the contract to perform examinations and audits and make excerpts and transcripts. The sub-contractor shall retain and keep accessible all financial and personnel records and books, documents, papers, plans, and writings for a minimum of five (5) years, or such longer period as may be required by applicable law, following final payment and termination of the MHO Agreement between the State of Oregon and MVBCN, or until the conclusion of any audit, controversy or litigation arising out of or related to the MHO Agreement, whichever date is later. The sub-contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit.
2. Attachment H, Fraud and Abuse: The sub-contractor shall cooperate with and participate in activities to implement and enforce MVBCN policies and procedures to prevent, detect and investigate fraud and abuse relating to OHP. The sub-contractor shall cooperate with authorized State of Oregon entities and CMS in activities for the prevention, detection and investigation of fraud and abuse. The sub-contractor shall allow the inspection, evaluation or audit of books, records, documents, files, accounts, and facilities as required to investigate an incident of fraud or abuse.