

Identifying, Investigating and Responding to Fraud, Waste and Abuse or Other Detected Offenses

Administrative Policy

Compliance

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Departments:	Compliance
Products:	All Products
Key Words:	Fraud, waste, abuse, investigation, monitoring, reporting, corrective, action, A056, FWA

RELATED DOCUMENTS:

[Prescription Drug Benefit Manual Chapter 9](#), [Medicare Managed Care Manual Chapter 21](#), and Medicare Advantage and Part D Fraud Handbook, [OIG Healthcare Fraud](#), [Department of Health Services Fraud](#) and [Contract for BadgerCare Plus and/or Medicaid SSI Jan 1, 2018 through Dec 31, 2019](#)

PURPOSE:

Security Health Plan (SHP) is committed to the responsible stewardship of our resources, and maintaining a comprehensive plan for detecting, preventing and correcting fraud, waste, and abuse (FWA). SHP staff are required to report any potential fraud, waste and abuse or illegal actions immediately and we expect and encourage reporting of any other potential compliance concerns as soon as possible. Any unethical and non-compliant activity must be reported to their manager, the compliance department or directly to the Chief Compliance Officer. SHP does not tolerate fraudulent or other dishonest behavior and will take appropriate investigative and corrective action upon receiving such reports.

DEFINITIONS:

Covered Individuals: SHP Board of Directors, Chief Executive Officer, senior management, managers, all other SHP staff including volunteers and consultants who work with, conduct business with, or on behalf of SHP are defined as Covered Individuals.

Fraud: An intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person. Fraud is an act that is committed knowingly, willfully, recklessly, or intentionally and may include, but is not limited to, the following:

- Theft or misappropriation of funds, supplies, property, or other resources;
- Forgery or alteration of documents (whether financial or operational);
- Undeserved payment for a claim, which can include provider services, durable medical equipment or prescription drug benefits;
- Unauthorized alteration or manipulation of computer files;
- Falsification of reports to management or external agencies;
- Billing for services not provided;
- Falsifying medical diagnoses or procedures to maximize payments;
- Misrepresentation of dates, descriptions of services, or identities of subscribers/providers;
- Billing for a more costly service than the one that was provided or billing for duplicate services;
- Accepting bribes for patient referrals;
- Billing for non-covered services as covered items (e.g., cosmetic);
- Providing false employer group and/or group membership information;
- Pursuit of a benefit or advantage in violation of the SHP Policy, Code of Business Ethics and Standards of Conduct;
- Authorization or receipt of compensation for hours not worked or unfulfilled contract requirements.
- Incorrectly performed business tasks.

Waste: Healthcare spending that can be eliminated without reducing the quality of care. Waste is the intentional or unintentional, thoughtless or careless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls. Examples of waste can include, but are not limited to, the following:

- Printing unnecessary handouts when it is available electronically;
- Printing items in color when black/white copies will suffice;
- Putting in unnecessary overtime when the workload and projects could be better managed by managers and staff;
- Making personal long-distance calls;
- Mismanaging office supplies; and

- Multiple contracts with same vendor

Abuse: Behaviors or practices of providers, physicians, or suppliers of services and equipment that, although normally not considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. The practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or which are medically unnecessary. Abuse describes incidents or practices that either directly or indirectly results in unnecessary costs that are wasteful to the Medicare/Medicaid program or other SHP programs, although it is not an intentional misrepresentation. Abuse can also occur with:

- Excessive charges;
- Improper billing practices;
- Payment for services that do not meet recognized standards of care; and
- Payment for medically unnecessary services.

Abuse can occur in financial or non-financial settings and can be a questionable practice, which is inconsistent with accepted medical, governmental or business policies.

POLICY:

This policy describes the procedure for covered individuals to report alleged acts of fraud, waste or abuse of SHP resources, and to describe SHP's procedure for responding to such reports. This policy applies to alleged acts of fraud, waste or abuse that have an actual or potential effect on one or more functional or operational aspects of SHP, or on SHP as a whole. Further, SHP will respond promptly to compliance issues as they arise, including the investigation of FWA and issues identified through the course of self-evaluation and/or audits. SHP must investigate and correct compliance issues thoroughly to reduce the potential for recurrence and ensure ongoing compliance with any federal or state laws, regulations, rules or guidance pertaining to any activities of SHP, including, among others, the Centers for Medicare & Medicaid Services (CMS), the Office of the Commissioner of Insurance (OCI) and the Office of Inspector General (OIG).

When to Report Fraud, Waste or Abuse or Other Program Noncompliance

All covered individuals, with a reasonable basis for believing FWA program noncompliance or other wrongful acts have occurred, are responsible for reporting such incidents to the Chief Compliance Officer. Concerns or inquiries reported to supervisors related to FWA or noncompliance must be reported to the Chief Compliance Officer.

It is not necessary to have proof of wrongdoing at the time of reporting dishonest or suspicious activity; however, anyone reporting such activity must have reasonable grounds for doing so. If wrongdoing is suspected, it should be reported immediately, without waiting to gather more

information. Investigations should only be conducted by the Chief Compliance Officer or at the request of the Chief Compliance Officer.

Monitoring/Auditing

Every SHP department is responsible for routine auditing and monitoring to ensure regulatory compliance.

SHP also has a special investigations unit (SIU) that utilizes sophisticated software to review claims for fraud, waste and abuse. Other instances of suspected fraud are also reviewed by SIU. Any cases of suspected fraud will be reported to the appropriate government agencies, including CMS, OIG or DHS and Wisconsin Medicaid Fraud Control Unit or other State agencies, as well as law enforcement, if necessary. Any instances or patterns detected are thoroughly investigated and resolved. SIU will refer any confirmed cases of FWA to the Corporate Compliance Officer which are then reported to the Corporate Compliance Committee members and a decision made and documented in the minutes.

SIU utilizes Cotiviti STARSSentinel software application to detect fraud, waste and abuse in medical and pharmacy claims. STARSSentinel aids SHP in the following aspects:

- Controls medical expenses and costs;
- Allows for larger volume of claims review with a focus on prioritizing claims issues with the largest recoupment of funds;
- Assists with detecting provider claim fraud, waste, and abuse submissions for reimbursement through various mechanisms of data analysis;
- Ensures through proactive data analysis providers and payers are in compliance with payment/reimbursement requirements; and
- STARSSentinel maintains a system that is updated with the most current claims review and rule information.

Compliance and other SHP departments promptly conduct investigations of potential compliance and FWA problems identified through monitoring, auditing and self-evaluation. Compliance maintains an excel log of its investigations, which will be reported to the Compliance Committee. Other departments such as Pharmacy also maintain a log of their investigations.

Education and Training Program

SHP staff is required upon hire, and annually thereafter, to complete a computer-based education and training program that provides staff with an overview of the compliance program, including fraud, waste, and abuse awareness. Agents and contractors are required, by contract, to have fraud, waste, and abuse educational training for their staff as well.

The detection and prevention of fraud, waste, and abuse, as well as the reporting of any potential incidents of fraud, waste or abuse for investigation, will be addressed by the SHP Chief Compliance Officer. SHP's commitment to the detection and prevention of fraud, waste, and abuse is shared with SHP's contractors and agents, providers, first tier, downstream and related entities by offering fraud, waste and abuse training access to the CMS MLN version through our Security Health Plan toolkit located on our website, and they must attest to their compliance annually.

How Security Health Plan Employees Report Fraud, Waste or Abuse

Several options are available to SHP staff for reporting alleged fraud, waste or abuse. Concerns may be reported as follows:

- SHP Chief Compliance Officer at: 715-221-9676
- SHP Compliance Hotline for fraud, waste, and abuse at 1-715-221-9570
- SHP Pharmacy Medicare Part D Hotline for Part D prescription fraud, waste, and abuse at 1-888-472-2363 or 715-221-9909
- External Hotline: 1-855-274-5540
- SHP director or manager
- Clicking on Compliance 360 icon, located on your desktop

Supervisors, department managers, or other SHP officials who receive reports of alleged fraud from any person, should immediately contact the Chief Compliance Officer at 715-221-9676 or the Compliance Hotline at 715-221-9570 for further assistance.

Do not confront or terminate the employment of a suspected employee, or accept the resignation of an employee, who is suspected of or who admits to fraudulent or other gross misconduct. The Chief Compliance Officer and/or Chief Legal Officer should be notified immediately.

Hotline reporting is further described in the policy and procedure: [Effective Lines of Communication](#).

Reporting Fraud, Waste and Abuse to the appropriate regulator

Security Health Plan's Chief Compliance Officer is responsible for reporting any suspected fraud, waste and abuse to the appropriate regulators outlined below. In the event the Chief Compliance Officer is unable to report the suspected FWA, a Compliance Specialist will be responsible for reporting the information.

Reporting Paths

- CMS-Medicare Fraud, Waste and Abuse reporting: <https://oig.hhs.gov/fraud/report-fraud/index.asp>

- How to report Medicare Fraud: <https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud>
- BadgerCare/Medicaid fraud, waste and abuse must be reported within 15 days of identification to : <https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx> or via the hotline 877-865-3432
 - The HMO must collaborate with OIG to complete the credible allegation of fraud referral ([F-02296](#)) and compile appropriate exhibits.

Security Health Plan will suspend payment for any provider where allegations of fraud, waste and abuse have been substantiated. Upon payment suspension Security Health Plan will notify the BBM and OIG of the suspension within 24 hours of the suspension of payment.

- ETF fraud, waste and abuse reporting, email to: InsuranceSubmit@etf.wi.gov
- Commercial fraud, waste and abuse reporting: <https://oig.hhs.gov/fraud/report-fraud/index.asp>

Medicaid Fraud Control and Elder Abuse Unit (MFCEAU)

Security Health Plan staff who become aware of potential Elder Abuse will enter a complaint notification in Salesforce, send an email to Care Management-Social Workers shared email as well as the Compliance shared email.

The Chief Compliance Officer is responsible for reporting any reported abuse of an adult. In the event of Elder Abuse notification, contact the county agency the individuals resides in. A welfare check will be initiated. Contact information can be found in the link below.

<https://www.dhs.wisconsin.gov/aps/ear-agencies.htm>

Investigations

The Compliance department takes all reports of Medicare or other misconduct and fraud, waste or abuse seriously. All reports of FWA received via the Compliance Hotline or to the Chief Compliance Officer will be reviewed to determine the nature and extent of the investigation required. Depending on the allegation, the Chief Compliance Officer may consult with other SHP departments or staff, including the Marshfield Clinic Health System (MCHS) General Counsel, MCHS Human Resources, SIU, or others as appropriate.

Pursuant to this policy, it is the duty of all covered individuals to cooperate fully in an investigation of non-compliance and/or FWA issues. Covered individuals that intentionally impede an investigation may be subject to discipline or other adverse employment action. SHP staff and/or any other covered individuals shall cooperate fully in an investigation to ensure honest, effective, and efficient working relationships with the Medicare Drug Integrity Contractors (MEDICs), OIG, CMS and law enforcement per SHP policy and procedure [Compliance – Governmental Audits, Interviews, Data Requests and Searches](#) (A058).

Medicare Drug Integrity Contractors (MEDICs)

MEDICs play an integral investigative role for Medicare and Part D programs. Their activities include:

- Data analysis to identify potential Medicare or Part D fraud;
- Investigation of potential Medicare or Part D fraud;
- Development of potential Medicare or Part D fraud cases for referral to law enforcement;
- Liaison to law enforcement for Medicare or Part D issues; and
- Audits of sponsor and subcontractor Medicare or Part D operations.

Voluntary self-reporting of federal law violations, significant Medicare program or other violations and potential FWA may also be made to CMS, OIG or, alternatively, to appropriate law enforcement authorities. SHP is required to report allegations of Medicaid fraud and abuse (both provider and member) to DHS within fifteen (15) days of the suspected fraud or abuse.

Maintaining Reporter Confidentiality

SHP shall take reasonable precautions to maintain the confidentiality of anyone who reports violations of the law or any SHP policy, even if no violations are substantiated. Confidentiality will be afforded to both the person making the report as well as to the person about whom the report is made. Anyone involved in conducting the investigation or in the reporting of alleged violations must comply with confidentiality requirements. The Chief Compliance Officer will maintain confidentiality to the fullest extent possible, but disclosure may be required if law enforcement becomes involved.

Reporting Internal Audit Irregularities to the Chief Compliance Officer

Internal audit irregularities should be reported to the Chief Compliance Officer by departmental directors, managers, and staff. The Chief Compliance Officer has the authority and objectivity necessary to investigate and report matters at SHP without regard to the length of service, job title, or relationship to SHP.

As a Medicare benefit sponsor, SHP will take appropriate corrective action(s) (for example, repayment of overpayments) in response to a finding of misconduct. Individuals found to have participated in fraud or other wrongful acts will be subject to disciplinary action, up to and including termination of employment, if appropriate. SHP may be required to report any wrongful acts to appropriate law enforcement for prosecution. MCHS Human Resources will make determinations in disciplinary matters after careful review of the facts and circumstances.

Protection Against Reprisal

No reprisal will be taken against any staff member for making a good faith report of a violation. Any instances of reprisal shall be reported to Human Resources for investigation. Employees and subcontractors as whistleblowers are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other applicable anti-retaliation protections. See also the [Whistleblower and Non-Retaliation Policy](#).

Corrective Action Plans (CAP)

Timely corrective action(s) will be taken for non-compliance, misconduct or fraud, waste, and abuse discovered by or reported to SHP, as appropriate. The Compliance Department will perform ongoing monitoring and/or auditing to ensure the effectiveness of the corrective action and/or the correction of any misconduct, and maintain related documentation according to the [Records Retention Policy](#). CAPs will be reported to the Corporate Compliance Committee and senior management on at least a quarterly basis.

Any corrective action(s) will be designed to correct the underlying problem that resulted in the program violation(s), provide training as needed and prevent future misconduct. The CAP will include timeframes for completion.

If the CAP is for misconduct committed by an SHP first tier, downstream and related entity, the corrective action will be detailed in a written agreement with the entity. The written agreement shall include ramifications should the subcontractor fail to satisfactorily implement the corrective action.

ACCOUNTABILITY:

All SHP staff are held accountable to this policy.