Payment Policy

Fraud, Waste, and Abuse Prevention Policy

Purpose

To establish a comprehensive plan to prevent, detect and correct fraud, waste, and abuse. To promote a sense of integrity and vigilance by means of comprehensive anti-fraud education. To provide information about the organization's procedures for detecting and preventing Fraud, Waste and Abuse.

Applicable Plans

- ☒ MHI MA Plans
- ☒ MHI NH Plans

Policy Statement

Minuteman Health ("MHI") is committed to complying with all applicable laws and regulations. All covered services must be delivered by appropriately licensed and accredited providers. Members and Providers are expected to truthful represent all clinical circumstances and only to use/provide clinical services that are medically necessary. As part of this commitment, MHI has established and will maintain a Corporate Compliance Program that includes a Fraud, Waste, and Abuse Prevention Program (FWAP Program). The MHI Compliance Officer is responsible for oversight of the FWAP Program. All Covered Individuals are expected to immediately report any potential false, inaccurate, or questionable claims or Suspicious Activity, as defined in the Procedure Section (see Appendix B for examples), to their supervisors, the MHI Compliance Officer, or the Compliance Hotline (855-400-0098). The MHI Compliance Officer will promptly investigate and report Suspicious Activity. MHI will not discriminate or retaliate in any way against any Employee or other party who reports a perceived problem, concern or Fraud, Waste, and Abuse issue in good faith.

Definitions

Abuse: Describes practices that, either directly or indirectly, result in unnecessary costs. Abuse also involves payment for services when there is no legal entitlement to payment.

Fraud: An intentional deception or misrepresentation that the individual knows to be false or does not believe to be true and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person.

Suspicious Activity: Any activity that an individual reasonably believes is fraudulent, wasteful, or abusive. Refer to Appendix A for examples of Suspicious Activity.

MHI Review Date: 10/23/2014, 10/7/2015, 11/01/2016

Waste: The inappropriate utilization and/or inefficient use of resources.

Requirements

Procedure

All MHI employees, vendors, brokers, members and providers must comply with all applicable state and federal law and regulation.

A provider's submission of a claim for payment constitutes a representation by the provider that the services or supplies reflected on the claim, including all quantities set forth on that claim:

- Were medically necessary in the provider's reasonable judgment;
- Were filed accurately, using complete and appropriate coding;
- Have been properly documented in the member's medical record(s);

A provider's submission of a claim for payment also constitutes the provider's representation that the claim is not submitted as a form of, or part of, fraud, waste and abuse)as defined above) and is submitted in compliance with all applicable state and federal laws and regulations.

Any amount billed by a provider in violation of this policy, if paid by MHI, constitutes an overpayment by MHI that is subject to recovery.

Any amounts billed to and paid by members in violation of this Policy, must be immediately refunded to such members. A Provider may not bill members for any amounts due resulting from violation of this Policy.

Providers who know of or suspect any fraud, waste and abuse activity should call MHI's toll-free anonymous hotline at (855) 400-0098.

Authorization Requirements

None

Attachments

Appendix A – Examples of Suspicious Activity (See below)

Important Note About This Reimbursement Policy

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance

with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. MHI's reimbursement policy includes the use of Current Procedural Terminology (CPT® [1]), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

MHI may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to MHI enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the MHI Provider Manual, and/or the enrollee's benefit coverage documents.

MHI reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

Resources

None

History

Updated 11/1/2015, 11/01/2016

APPENDIX A
Examples of Suspicious Activities

MHI Employees and MHI or Agents should be alert to these and other Suspicious Activities:

Providers:

- Billing for services or supplies that were not provided. This includes billing for "no shows" (for example, billing members for services that were not actually furnished because the patients failed to keep their appointments)
- Misrepresenting the diagnosis for the patient to justify the services or equipment furnished
- Altering claim forms or medical records to obtain a higher payment amount
- Deliberately applying for duplicate payment (for example, billing MHI and the member for the same service or billing both MHI and another insurer in an attempt to get paid twice)
- Soliciting, offering, or receiving a kickback, bribe, or rebate (for example, paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment)
- Unbundling or billing for separate portions, rather then for the whole procedure (for example, the billing of a multi channel set of lab tests to appear as if the individual tests had been performed)
- Characterizing the service differently than the service actually rendered or misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services (for example, falsely indicating that a particular healthcare professional attended a procedure)
- Upcoding to maximize payments (for example, billing for 45-50 minutes of psychotherapy when the documentation states 20-30 minutes face to face psychotherapy)
- Using unlicensed staff and billing for their services as if provided by a licensed health care professional or physician
- Performing unnecessary procedures, tests, or even surgeries or prescribing additional and unnecessary treatments (over-utilization) or more expensive than indicated medications (drug diversion)
- Requiring a member to return for unneeded follow-up services
- Balance billing members for services
- Billing for non-covered services as covered services (for example, routine foot care billed as a more involved form of foot care to obtain payment)
- Participating in schemes that involve collusion between a provider and a member, or between a supplier and a provider that result in higher costs or charges
- Utilizing split billing schemes (for example, billing procedures over a period of days when all treatment occurred during one visit)
- Billing for “phantom” providers who are not really doctors, dentists, or health care professionals, who attempt to get money from a health plan by submitting claims on real members that they have not seen. These providers may or may not supply a W-9 and do not have licenses to perform the services.
- Billing for “phantom” patients who do not exist and did not receive services
- Billing for more hours than there are in a day

Members:

- “Loaning” or using another person’s insurance card to obtain medical care and benefits
- Providing false information when applying for programs or services
- Filing requests for reimbursement for services or medications not received
- Adding an ineligible dependent to the plan or not taking a dependent off a policy when the dependent is no longer eligible for coverage
- Failing to disclose multiple coverage policies, or leveraging various coverage policies to “game” the system, resulting in improper coordination of benefits.

- Using a false home address to obtain coverage when your primary address is out of the service area
- Forging or altering bills or receipts to obtain inappropriate reimbursement from the health plan.
- Forging or altering a prescription or improperly obtaining prescriptions for controlled substances.
- Obtaining prescription drugs from a provider, possibly for a condition from which the member does not suffer, and giving or selling this medication to someone else.
- Doctor shopping: Member consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might also be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Non-Members

- Using a stolen member card for obtaining medical services, including medical supplies and prescriptions

Brokers and Agents:

- Altering documents
- Accepting or offering kickbacks or bribery
- "Clean sheeting" or falsifying or misrepresenting member or group information to obtain better rates. This act makes the applicant for coverage appear to be a better risk for policy acceptance.
- Failure to disclose information that may affect conditions of coverage
- Sale of non-existent policies

Employers:

- Providing false employer or group membership information to secure healthcare coverage
- Falsifying information
- Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- Falsifying an employee hire date to modify the date of health care coverage
- Falsifying an employee termination date in order to eliminate premium payments

Employees or Health Plan:

- Fabricating claims
- Risk Adjustment
- Participating in schemes that involve collusion between a provider and an employee where the claim is assigned (for example, the provider deliberately over-bills for services, and the employee then generates adjustments with little or no awareness on the part of the member)
- Manipulating claims data on unassigned claims for one's own benefit (for example, through manipulation of member address or the claims history record, an employee could generate adjustment payments against many member records and cause payments to be mailed to an address known only to him/her)
- Failing to provide medically necessary items or services that the organization is required to provide (under law or under the contract) to a member, and that failure adversely affects (or is substantially likely to affect) the member.
- Marketing Schemes: When a health plan, or its subMHI, violates the Medicare or Medicaid marketing guidelines, or other federal or state laws, rules, and regulations to improperly enroll members. Examples of such violations include, but are not limited to:
  - Offering members a cash payment as an inducement to enroll in a Medicare or Medicaid plan;
  - Unsolicited door-to-door marketing;
  - Use of unlicensed agents;
  - Enrollment of members without their knowledge or consent;
  - Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS;
  - Misrepresenting the product being marketed as an approved Medicare Plan when it actually is a Medigap policy or non-Medicare plan;
  - Requesting member financial information or check numbers (potential identity theft by marketing agents).

- Requiring members to pay premiums up front.

- False statements related to procuring a managed care contract, including but not limited to:
  - Falsification of health care provider credentials by the health plan or subMHIs
  - Falsification of financial solvency
  - Falsified or an inadequate provider network
  - Fraudulent subcontract
  - Fraudulent subMHI
  - Bid-rigging (collusion between State employees and those submitting Request for Proposals and/or contracts) or self-dealing (award of Medicaid contracts based on friendship or family relationships with those in control of the selection process)
  - Illegal tying agreements (subMHI requires the health plan to contract with other entities as a condition for the subMHI to provide services)
- Payments for excluded services, items, or drugs.
- Inappropriate Enrollment/Disenrollment (for example, "Cherry-picking" or selecting the healthiest segment of the enrollment population or disenrolling undesirable members)
- Misrepresenting or falsifying information furnished to members.
- Not correcting inaccuracies in eligibility or coordination of benefits
- Underutilization, for example:
  - Untimely first contact with clients
  - Untimely assignment of a primary care physician (PCP)
  - Delay in reassigning PCP upon an individual's request
  - Discouragement of treatment using geographic or time barriers (assigning PCP located far from the member's home or who offers limited office hours or has long waiting times)
  - Engagement in any Federally-prohibited discrimination activities
  - Failure to serve individuals with cultural or language barriers
  - Failure to provide educational services (for example, if the health plan contract requires health education or certain preventive services, such as smoking cessation education, a health plan can save expenses if it does not advertise or provide these services)
  - Failure to provide outreach and follow-up care or Federally-required referrals (for example, a health plan can save expenses by not advertising services, and therefore, members do not receive these services because they do not know they can be provided)
  - Failure to provide court-ordered treatment for health care that is medically necessary
  - Failure to provide members under a government contract comparable services such as those provided to commercial or fee-for-service members
  - Defining "appropriateness of care" and/or "experimental procedures" in a manner inconsistent with standards of care
  - Delaying including approved pharmaceuticals on the formulary thereby avoiding the use of expensive new drugs
  - Strict Utilization Review (UR) standards (for example, a health plan can hide its poor performance and lack of service delivery by adopting inappropriate utilization review guidelines)
  - Cumbersome appeal process for enrollees (for example, a health plan can save or delay expenses by inhibiting appeals or by creating burdensome appeal procedures for clients who are refused specific care)
  - Ineffective grievance process (for example, a health plan can appear to have fewer complaints than it actually does by adopting difficult-to-follow grievance procedures)
  - Inadequate prior authorization "hotline" (for example, a health plan requires a provider to obtain prior approval before performing a certain procedure, but fails to respond in a timely manner to such requests; once the procedure is performed, the claim may be denied because of lack of prior approval)
  - Unreasonable prior authorization requirements (for example, a health plan has a prior authorization process that makes it stringent or otherwise difficult to acquire approval for standard or routine care)
  - Cumbersome appeals process for providers (for example, a health plan can discourage providers from filing appeals by routinely delaying or "losing" appeals)
  - "Gag orders"or establish restrictions that prevent a PCP from freely advising the patient about his or her health status and limit discussion of alternative medical care or treatment for a condition or disease (prohibited by federal and state law)
  - Incentives to PCPs and specialty providers to illegally limit services or referral

- Routine denial of claims (for example, routinely denying claims that unquestionably qualify as medically necessary services under the plan)

- Embezzlement, Theft, and Related Fee-For-Service Fraud
  - Embezzlement and theft -- Officers of the MCO or subcontracting providers steal or appropriate property entrusted to their care for their own use
  - Diversion of funds for medical service to unnecessary administrative costs
  - "Bust outs" --Premiums are paid to the MCO, but the MCO avoids paying vendors/providers by deliberately declaring bankruptcy.