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Chapter 11

FRAUD AND ABUSE

CMDP follows the Arizona Health Care Cost Containment System (AHCCCS) fraud and abuse provisions. Reported incidents of fraud and abuse will be investigated by AHCCCS and may result in legal action.

Definitions of Fraud and Abuse

- FRAUD (by member or provider) means 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. (42 CFR 455.2)
- ABUSE (by provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2)
- ABUSE (of a member) means any intentional knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault. (A.R.S. § 46-451, A.R.S. § 13-3623)
- INCIDENT means a situation of possible fraud, abuse, neglect and/or exploitation as defined in the policy that has the potential for liability.

Corporate Compliance

The Corporate Compliance program formalizes and affirms CMDP's commitment to the legal and ethical behavior of our employees.

CMDP Code of Conduct

The CMDP Code of Conduct provides guiding standards for employees to make the right decision when encountering situations involving legal and ethical issues in their daily activity. The CMDP Code of Conduct cannot cover every situation, or substitute for common sense, individual judgment and personal integrity. It is the duty of each CMDP employee to follow these principles:

1. **Respect the rights, dignity and diversity of each individual.** CMDP is dedicated to providing high quality health plan services that meet the needs of our members. CMDP respects the rights, dignity and cultural diversity of each individual and prohibits discrimination in any form or context.

2. **Maintain the appropriate levels of confidentiality for information and documents.** CMDP is dedicated to protecting the privacy of our members by preserving the confidentiality of individually identifiable health information, whether or not such information is maintained electronically, in writing, is spoken or in any other medium. (HIPAA)
3. **Comply with all applicable laws.** CMDP conducts business activities in full compliance with all applicable federal, state, and local laws and regulations.
4. **Conduct CMDP affairs in accordance with the highest ethical standards.** CMDP conducts all activities in accordance with the highest ethical standards of the community and their respective professions at all times. No employee shall make false or misleading statements to any member, provider, person or entity doing business with CMDP.
5. **Ensure proper payment for services.** CMDP is committed to ensure all requests for payment for healthcare services are (i) reasonable, necessary and appropriate; (ii) provided by properly qualified persons and (iii) the claims for such services are coded and billed correctly and supported by appropriate documentation.
6. **Avoid conflicts of interest.** CMDP takes all reasonable precautions to avoid conflicts, or the appearance of conflicts, between our private interests and the performance of our official duties.
7. **Protect and properly utilize all assets.** CMDP protects and properly utilizes all assets, such as property, equipment or resources that are entrusted in their care.
8. **Provide a safe working environment.** CMDP is committed to maintaining a safe and healthy working environment, which complies with all relevant laws and regulations.
9. **Provide equal opportunity to each employee.** CMDP treats all applicants and employees fairly and equitably, and in accordance with all relevant federal, state, DES and DCYF rules and regulations, policies or procedures. CMDP is committed to employment and promotional opportunities for all persons, without regard to race; color, nationality or ethnic origin, religion, gender, sexual orientation, disability or veteran's status.
10. **Promote open communication.** CMDP encourages open and candid communication and responds to issues and concerns in a timely manner.
11. **Conduct all business with honesty and integrity.** CMDP employees shall prepare accurate financial reports, accounting records, research reports, expense accounts, time sheets and other documents so that they completely and accurately represent the relevant facts and true nature of all CMDP business transactions.

12. **Safeguard against conflicts of interest.** All internal and external CMDP committee members sign Confidentiality and Conflict of Interest statements. The principles of these statements are reviewed at the start of each committee meeting.

Corporate Compliance Hotline

The CMDP Corporate Compliance Hotline is the confidential, 24 hours a day, 7 days a week voice mailbox of the CMDP Compliance Officer. Anyone can use this resource to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal or unacceptable practices or compliance violations.

All calls are kept confidential to the extent permitted by law. Although callers are encouraged to identify themselves, the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct. Actions are taken equitably and consistently.

Reports can be made by calling the CMDP Compliance Officer at (602) 771-3555, or (800) 201-1795 Ext. 13555.

Fraud, Waste and Abuse Reporting

To report fraud, waste and abuse directly to the AHCCCS Office of the Inspector General (OIG), go to the AHCCCS Fraud and Abuse webpage, **www.azahcccs.gov/fraud/reporting/reporting.aspx**, and follow the instructions provided. All pertinent documentation and/or investigative reports that would assist AHCCCS in its investigation shall be attached to the forms submitted.

Examples of Fraud and Abuse

Examples of fraud and abuse include, but are not limited to:

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Falsifying Services

- Billing for services/supplies not provided
- Misrepresentation of services/supplies
- Substitution of services

Administrative/Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices

- Fraudulent third party liability reporting
- Fraudulent recoupment practices

Member Issues (Abuse)

- Physical or mental abuse
- Emotional or sexual abuse
- Discrimination
- Neglect
- Financial abuse
- Providing substandard care

Member Issues (Fraud)

- Resource misrepresentation (transfer/hiding)
- Residency
- Household composition
- Citizenship status
- Unreported income
- Misrepresentation of medical condition
- Failure to report third party liability

Denial of Services

- Denying access to services/benefits
- Limiting access to services/benefits
- Failure to refer to a needed specialist
- Underutilization*Billing fraud and abuse* is an umbrella term that applies to a series of statutes and regulations designed to prevent government health programs from paying excessive and/or inappropriate claims. The United States General Accounting Office (GAO) estimates that medical billing fraud and abuse approaches 10% of all health care expenditures, or $100 billion dollars yearly.

Provider Prevention

There are several things healthcare providers can do to help prevent allegations of billing fraud and abuse. They include the following:

- Complete claim forms accurately.
- Ensure that patient records corroborate that services were actually rendered and necessary.
- Develop and install a comprehensive internal fraud detection and compliance plan.

Healthcare providers should develop internal mechanisms to ensure compliance with complex and constantly changing Medicare and Medicaid regulations. The benefits of an internal fraud detection and compliance program include early detection of problems, prevention of submitting improper claims, subversion of employees ability and inclination

to bring a *qui tam* lawsuit, and the opportunity to voluntarily disclose fraud or mistakes, possibly reducing penalties and fines.

The Federal False Claims Act

The False Claims Act (FCA) provides a powerful legal tool to counteract fraudulent billings reported the federal government. Any private citizen with direct knowledge of fraud can bring a false claims suit on behalf of the government. Private litigators are given standing to file civil suit on the federal government's behalf by the FCA's *qui tam*, or "whistleblower" provisions. Qui tam is short for *qui tam pro domino rege quam pro se ipso in hoc parte sequitur* or "he who brings the action for the king as well as for himself [sic]."

To encourage whistleblowers to come forward, the FCA entitles them to a share/percentage of any money resulting from a judgment against, settlement with, or recovery from the defendant.

Healthcare providers should be aware that all employees, sub-contractors, agents, representatives, shareholders, vendors, competitors, clients and the like are potential whistleblowers or *relators*. If the government doesn't join in the case, the relator can pursue it alone.

Relevant Federal Laws

- 31 U.S.C. § 3729 et seq.: Federal False Claims Act
- 42 U.S.C. §1320A-7b(b)(1): Anti-Kickback Prohibition
- 18 U.S.C. § 1035: False Statements Relating to Health Care Matters
- 18 U.S.C. § 287: Federal Criminal False Claims Act
- 18 U.S.C. § 1001: Federal Criminal False Statements
- 18 U.S.C. § 1347: Health Care Fraud
- 18 U.S.C. § 1341: Mail Fraud
- 18 U.S.C. § 1962: Racketeer Influenced and Corrupt Organizations (RICO) Act
- 42 U.S.C. § 1395nn: Self Referral Prohibition (Stark Amendment)
- 18 U.S.C. § 1343: Wire Fraud

Related State Laws

Arizona does not specifically have a state false claims law. The state does have related statutes governing the following:

- A.R.S. § 13-1802: Theft
- A.R.S. § 13-2002: Forgery
- A.R.S. § 13-2310: Fraudulent schemes and artifices
- A.R.S. § 13-2311: Fraudulent schemes and practices; willful concealment
- A.R.S. § 36-2918: Prohibited acts

The Whistleblower Provision

A relator that files a False Claims Act suit receives an award only **if and after** the government recovers money from the defendant as a result of the suit. Generally, the court may award 15 to 30 percent of the total recovery from the defendant, whether through a favorable judgment or a settlement. The amount of the award depends, in part, upon:

- If the government participates in the suit.
- The extent to which the person substantially contributed to the prosecution of the action.

Whistleblower Protection

United States Code Title 31, Section 3730(h) provides protection to employees who are retaliated against by an employer because of the employee's participation in a *qui tam* action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his/her employer because the employee investigates, files or participates in a *qui tam* action.

The whistleblower protection includes reinstatement at the same seniority level and damages of double the amount of lost wages plus interest if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

Administrative Remedies

The federal False Claims Act carries serious fines for healthcare providers who knowingly submit or cause the submission of fraudulent claims to federal payment programs, such as Medicaid or Medicare. Liability to a company or an individual for violating the FCA may include damages of up to three times the dollar amount that the government is found to have been defrauded, civil penalties of not less than $5,500 and not more than $11,000 for each false claim, and the attorney's fees of the relator. Individuals or companies that cause someone else to submit a false claim can also be found liable under the FCA.

Provider Training

Provider Training Resources

The CMDP Corporate Compliance program requires CMDP healthcare providers to train their staff in fraud and abuse awareness. We offer training supports through the *CMDP Provider Manual* and CMDP web site. The following aspects of the FCA are included in this information:

- An overview of the FCA;
- The administrative remedies for false claims and statements;
- Additional federal and state laws relating to civil and criminal penalties for false claims and statements;
- The whistleblower protections under such laws.

Training Web Site Links
The AHCCCS web site has a comprehensive page on fraud and abuse, which contains computer-based training courses in fraud awareness. Go to **www.azahcccs.gov/fraud/Default.aspx**, and click on the Fraud Awareness for Providers link shown on the page.

HIPAA Compliance

In 1997, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA impacts the entire health care industry. The primary objectives of HIPAA are to ensure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information. In part, HIPAA is intended to improve the efficiency and effectiveness of the health care system through the establishment of standards, and to protect the security and privacy of health care information.

Health plans, health care clearinghouses and health care providers must comply with HIPAA requirements pertaining to the use of standardized transaction code sets (TCS), ensure privacy standards are followed, and protect the security of health information.

CMDP has assessed its obligations under HIPAA with a determination that CMDP is performing HIPAA-covered functions. Consequently, CMDP must comply with the applicable HIPAA provisions for privacy, electronic transactions, and security.

Confidentiality of health information for CMDP members has always been of the utmost importance. HIPAA emphasizes the privacy protections, and establishes specific standards for the use and disclosure of protected health information. For information about CMDP's privacy practices, or other HIPAA-related information pertaining to CMDP members, write to the CMDP Privacy Officer at:

DES/CMDP
Attn: Privacy Officer
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202

If you have questions relating to electronic transactions or transaction code sets, please contact the Chief Information Officer (CIO) at:

DES/CMDP
Attn: Chief Information Officer
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202

Additional HIPAA References
For further information about HIPAA, see:

- U.S. Department of Health and Human Services, Office of Civil Rights web site, **www.hhs.gov/ocr/hipaa**
- The Department of Economic Security HIPAA web page, **www.azdes.gov/hipaa**
- Federal statutes, 45 CFR §164.534 (**www.gpoaccess.gov/cfr/**)
- State statutes, A.R.S.§ 13-3620(D) (**www.azleg.gov/ArizonaRevisedStatutes.asp**)

Confidentiality

All information regarding identification and treatment of CMDP members is confidential (A.R.S. §§ 8-807, 13-3620(D), and 41-1959). Information regarding CMDP members, including records and files, may be released to:

- CMDP personnel;
- Staff of the custodial agency;
- Law enforcement personnel; or
- Other physicians and treatment staff providing medical services to the member, and foster caregivers.

All requests to the provider for confidential medical information from persons not listed above should be referred to the child's assigned custodial agency representative.

A provider may not release medical information to anyone not listed above without a signed authorization by the custodial agency representative or legal guardian.

Authorization for release of information must be a written document, separate from any other document and the signature must be obtained from the designated representative, and must specify the following:

- Information or records, in whole or in part, which are authorized for release;
- To whom the release shall be made;
- The period of time for which the authorization is valid, if limited; or
- The dated signature of the designated legal representative.

Providers may use their own medical information release forms.