6002-N FRAUD AND FALSE CLAIMS

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REFERENCES: A.R.S. § 13-1802, 13-2002, 13-2310, 13-2311, 36-2918; A.A.C. R6-6-801 et seq., R6-6-1001 et seq., R6-6-1101 et seq., R6-6-1501 et seq.; 42 CFR 455.2.

Overview

This policy provides an overview of key provisions of the False Claims Act (FCA) and related legal requirements as required by the Deficit Reduction Act of 2005 (DRA) for the Division of Developmental Disabilities (Division). This policy defines fraud and describes the procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

A. Prevent or detect fraud and abuse.

B. Delineate reporting requirements.

C. Define procedures.

D. Explain Corporate Compliance.

E. Describe training requirements.

F. Specify policy requirements for providers.

Definitions

A. Abuse - Per 42 CFR 455.2, *Abuse* means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid 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 beneficiary practices that result in unnecessary cost to the Medicaid program.

B. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules and regulations published in the Federal Register by the departments and agencies of the Federal Government.

C. Claim – Under the FCA, the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

D. Deficit Reduction Act –The Deficit Reduction Act of 2005 (DRA), is a United States Act of Congress concerning the budget (Public Law No: 109-171 (02/08/2006)). It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management,

contractors and agents regarding the False Claims Act.

E. False Claims Act - The FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs (31 U.S.C. § 3729-3733). It is the federal Government's primary litigation tool in combating fraud against the Government. The law includes a *qui tam* provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." 42 CFR 455.2

1. An act of fraud has been committed when a member or provider:

   a. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

   b. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

   c. Conspires with others to get a false or fraudulent claim paid by the federal government.

   d. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government

G. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

H. Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practice, it may conduct a preliminary fact-finding to determine whether there is a sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

I. Prevention - Keep something from happening.

J. Primary Contact - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS in the manner prescribed in this policy.

K. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

L. Remit Advice - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

M. Waste - As defined by the Arizona Health Care Cost Containment System (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

Prevention and Detection

The Division is committed to fostering a culture of compliance and an environment conducive to preventing and detecting fraud, waste, and abuse. The Division provides training to its employees about their role in reporting concerns and problems in relation to compliance and ethics. All Division employees are required to report any concerns relating to potential fraud, waste, and abuse, including false claims. This responsibility is intended to allow the Division to monitor and do improvement planning pertaining to false claims processing or other aspect of organizational compliance. Any employee who fails to report properly either through internal lines of communication or to AHCCCS OIG, when that person knows of conduct constituting a violation of the FCA or any other related legal provision in the Division's Corporate Compliance program, will be subject to discipline, up to and including termination.

As part of the Division's Compliance Program objectives, all employees, contractors, agents, subcontractors, in particular those involved in the provision or arrangement of provision of services, under government programs including members and providers, must report potential violations of this policy. Reports may be made anonymously; the person doing the reporting may request confidentiality and will be protected from any retaliatory action.

A. The Division establishes internal controls on the member payment system including claim edits and prior authorization requirements. The Claims System is used to prevent and/or detect payments to providers when services were not performed, not authorized, or otherwise inappropriate. The original claims process is tested for the validity of its ability to detect fraud and misuse by reporting high utilization by members (CLT_0060), underutilization by members (CLT_0150), inappropriate service costs, and analyzing units by service title, month by month over the fiscal year. referral to AHCCCS OIG for suspicion of fraud, waste, or abuse. The Business Operations Unit conducts a post-payment review process, as outlined below:

B. Claims Edits

Claims are edited through a computerized system. During the initial processing of a claim, the claim is reviewed for items such as member eligibility, covered services, excessive or unusual services, duplication of services, prior authorization, invalid rate codes, and duplicate claims. Claims over a certain amount are automatically referred for review if the provider has exhausted all authorized units.

The Division segregates the functions of service authorization and claims processing.

C. Post Processing Review of Claims

Once claims are paid, the Division conducts a retrospective review of a sample of claims to ensure that the processing of the claim was specific to the processing instructions for the specific review. The Division conducts audits of claims payments to attain reasonable

assurance that payments are being prepared correctly for the claims submitted by authorized providers for eligible AHCCCS members. The Division reviews detailed remittance advice. The Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

D. Prior Authorization

All services must receive prior authorization. Prior authorization criteria are determined using the guidelines set forth in DDD Provider Policy Manual, Chapter 17, Prior Authorization, and the AHCCCS Medical Policy Manual.

E. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

F. Contract Provisions

All providers must comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement."

G. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff.

Report suspected fraud, waste, or abuse via one of the following:

1. Call the toll free DES/DDD Hotline at 877-822-5799.
2. Report the incident by completing the online referral form: https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud
3. Mail to:

   DES/DDD
   Attention: Corporate Compliance Unit
   1789 W. Jefferson Street
   Phoenix, AZ 85007

4. Email: DDDFWA@azdes.gov
5. Contact AHCCCS through their website: https:/www.azahcccs.gov/Fraud/AboutOIG/

False Claims Act

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. The FCA and related law commits that no person will be subject to retaliatory action as a result of their reporting of credible misconduct. Pursuant to the Division's commitment to compliance with the relevant FCA and other applicable laws, no employee will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the Division solely because of actions taken to report potential fraud, waste and abuse, or other lawful acts by the employee in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

Corporate Compliance

The Corporate Compliance Officer implements, oversees, and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer must be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the Compliance Committee meeting held at least once quarterly. The committee is a body comprised of the Chief Compliance Officer and Executive Leadership. Executive Leadership is limited to the following positions/designees:

- Assistant Director/Chief Executive Officer
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer

- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The Corporate Compliance Committee meeting includes information that has been forwarded for review through more frequent standing committees such as the bi-weekly Contract Compliance Committee. Information that may be included at a Corporate Compliance Committee meeting includes but is not limited to:

- Incident Management System data (including suspected fraud)
- Consumer Resolution System data
- Program Monitoring reviews; claim disputes, appeals and state fair hearings
- Monthly meetings between the Attorney General's Office, Office of Administrative Review, Assistant Director and Executive Leadership to review any pending litigation
- Compliance Risk Management data analysis and remediation
- Development of strategies to promote compliance and detect any potential violations
- Development, implementation and monitoring of Corrective Action Plan (CAP)
- Training and Education
- Review of Compliance policies and procedures
- Approval of Standards of Conduct
- Identify staffing needs and resources of the Compliance Unit
- Communications to all colleagues regarding compliance issues (e.g., HIPAA, Codes of Conduct violations, Whistleblower Protections, False Claims)

The committee makes recommendations for improvement of the compliance program as identified through the analysis and review of reports. This committee is authorized to implement or require implementation of all necessary actions to ensure that the Division achieves the goals of an effective compliance program.

Training

The Division has available training through both the continuous core curriculum as well as

Computer Based Training regarding fraud, waste and abuse. The Corporate Compliance Unit provides standalone in-services to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.