Chapter 20 FRAUD, WASTE, AND ABUSE

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REFERENCES: 42 CFR 455.2; A.R.S. §§ 46-451 and 13-3623

PURPOSE

The Division of Developmental Disabilities (Division) is committed to the prevention and detection of fraud, waste, and abuse. Providers are responsible to administer internal controls to guard against fraud, waste, and abuse (FWA). This policy defines FWA and describes procedures for the prevention and detection of FWA, delineates reporting requirements for FWA, describes provider training requirements for FWA, and specifies FWA policy requirements for providers.

DEFINITIONS

1. "Abuse" means the 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 which 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 as specified in 42 CFR 455.2.

2. "Code of Federal Regulations (CFR)" means the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

3. "Claim" means Under the False Claims Act (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.

4. "Deficit Reduction Act (DRA)" means the DRA of 2005 is a United States Act of Congress concerning the budget. 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 shall implement written policies for its

employees, management, contractors, and agents regarding the FCA.

5. "False Claims Act (FCA)" means 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. 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).

6. "Fraud" means 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)

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

b. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

c. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

d. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

e. 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

7. "Internal Audit Administration (IAA)" means a functional administration within the Department of Economic Security (DES), Office of Inspector General (OIG); Internal Audit Administration (IAA) conducts performance audits of agency systems and programs, and compliance audits of contractors to identify risk, recommend corrective actions to prevent or mitigate issues, recoup improper payments, and assess compliance with laws, regulations, and standards. In addition to

identifying factors inhibiting performance, IAA audits assist in evaluating the effectiveness of programs, activities, and functions; determining whether measures of program effectiveness are valid and reliable; and assessing whether management has considered alternatives that might increase the likelihood of achieving desired results or improve the efficiency or effectiveness of strategies and solutions. The authority to conduct audits of its contracts and subcontracts is derived directly from the Arizona Revised Statute A.R.S. § 35-214.

8. "Prevention" means to keep something from happening.

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

10. "Waste" means as defined by 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.

POLICY

A. Prevention and Detection

The Division is committed to fostering a culture of compliance which is conducive to preventing and detecting fraud, waste, and abuse by requiring its providers, agents, and subcontractors to provide ongoing training to their employees, and to become knowledgeable about their role in reporting concerns and problems in relation to fraud, waste, and abuse. All providers, agents, and subcontractors 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 aspects of Corporate Compliance. Any provider, agent, or subcontractor who fails to report properly either through their internal lines of communication, the Division, 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, they will be subject to contract action.

As part of the Division's Compliance Program objectives to detect, prevent and remedy potential, incidents of fraud, waste, and abuse, it is the policy of the Division that all providers, agents, and subcontractors, in particular those involved in the provision of services or arranging for the provision of services under government programs including members and providers, to report matters which involve 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.

B. Division Monitoring

The Division:

1. Reviews all participating providers during the credentialing/certification process (including re-credentialing)
2. Monitors providers for non-compliance with Division contracts, rules, policies, and procedures, in addition to AHCCCS policies.
3. Verifies as part of Prior Authorization (PA):

a. Member eligibility

b. Medical necessity

c. Appropriateness of service being authorized

d. Service being requested is a covered service

e. An appropriate provider referral.

The Division's electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud, waste, and abuse. Some of these edits include member eligibility, covered services, prior authorization, appropriate services codes, dates of services, authorized units and units provided, duplicate claims, approved rates, and utilization.

The Division, with the support of the IAA, conducts post-payment reviews. The Division Post Payment Review guidelines are consistent with statewide standard uniform procedures used to identify, review and correct billing discrepancies. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These Include the review of provider files, such as timesheets, to ensure proper documentation. The Division may refer billing discrepancies to other entities for further action. In cooperation with

other program integrity sources, the Division, at all levels, is committed to preventing and detecting overpayments resulting in the recoupment of monies due to billing discrepancies.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as-needed basis.

If at any time during the above processes, the incidence of fraud, waste, and/or abuse is suspected or discovered, the matter is referred to the Division's Corporate Compliance Unit for review and potential referral to the AHCCCS OIG.

C. Provider Requirements

1. Training and Education

   As a condition for receiving payments, providers shall establish written policies, and ensure adequate training and ongoing education for all of its employees (including management), members, and any subcontractors and/or agents of the Provider regarding the following:

   a. Detailed information about the Federal False Claims Act,

b. The administrative remedies for false claims and statements,

c. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and

d. The whistleblower protections under such laws.

2. Reporting Fraud, Waste and Abuse

When a provider becomes aware of an incident of potential/suspected fraud, waste, or abuse, the provider shall report the incident to the Division within one business day of becoming aware of the incident.

D. Fraud Contact Information

To report suspected fraud, waste, or abuse of the program, the provider shall make contact with one of the following:

1. DDD Corporate Compliance Unit

a. Phone: 1-877-822-5799.

b. Online:

https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

c. Email: DDDFWA@azdes.gov

d. Or Write to:

e. DES/DDD

Attn: Corporate Compliance Unit

1789 W. Jefferson Street

Phoenix, AZ 85007

2. AHCCCS OIG Fraud Prevention Unit

a. Phone: 602-417-4193

b. Online:

https://azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

3. Provider Fraud:

a. Maricopa County: 602-417-4045

b. Outside Maricopa County: 1-888-487-6686

4. Member Fraud:

a. Maricopa County: 602-417-4193

b. Outside Maricopa County: 1-888-487-6686

5. General Questions:

a. Email: AHCCCSFraud@azahcccs.gov