
TITLE:

Fraud and Abuse Prevention

PURPOSE:

To assign responsibility for preventing, detecting, reporting and investigating fraud and abuse, to ensure Medicaid program integrity and compliance with state and federal rules and regulations governing Fraud and Abuse.

POLICY:

First Coast Advantage (FCA) is committed to complying with all applicable fraud and abuse laws. As part of this commitment FCA has established and will maintain a Corporate Compliance Program that includes a Fraud and Abuse Program. Employees, medical/professional staff and contractors are expected to immediately report any potential false, inaccurate or questionable claims.

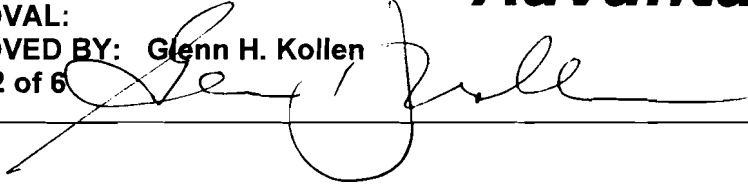
DEFINITIONS:

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Agency for HealthCare Administration (AHCA) and/or Medicaid program to himself, the corporation or some other person. It also includes any act that constitutes fraud under applicable Federal or State of Florida health care fraud laws.

Abuse – Provider and Plan practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the AHCA and/or Medicaid program, including but not limited to practices that result in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost to AHCA and/or the Medicaid program.

Contractor or Agent – Includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnished, or otherwise authorize the furnishing of, Medicaid health care items or services, performing billing or coding functions, or is involved in the monitoring of health care provided by the entity.

Employee – Includes any officer, director, manager and employee of Shands Jacksonville Medical Center First Coast Advantage.



PROCEDURE:

1. Employees, providers and contractors must immediately report suspected false, inaccurate or questionable claims or actions, as well as questions, concerns or potential fraud or abuse to:
 - a. Immediate supervisor
 - b. Chief Compliance Officer/Director
 - c. Confidential and anonymous, toll free Hotline, 24 hours/day, 365 days/year at 1-888-329-3569.

2. Employees, providers and contractors may also report suspected false, inaccurate or questionable claims or actions to:
 - a. Florida Consumer Complaint Hotline: 1-888-419-3456
 - b. Florida Office of the Attorney General: 1-866-966-7226
 - c. Medicaid Program Integrity 1-888-419-3456 or 1-850-922-4448

3. All allegations of fraud and abuse reported pursuant to this policy and/or Shands HealthCare Core Policy 4.11 Compliance Violation Reporting and Non-Retaliation will be investigated and a complete follow up report made

4. FCA will not discriminate or retaliate against any employee, medical/professional staff, or contractor for reporting a potential fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution.

5. FCA shall immediately report in writing any confirmed or suspected provider, enrollee, or transportation services provider fraud and abuse under state and/or federal law to the Agency Contract Manager, the Bureau of Medicaid Program Integrity (MPI), and the Medicaid Fraud Control Unit (MFCU).

6. FCA shall also immediately report in writing to the Agency Contract Manager, the Bureau of Medicaid Program Integrity (MPI), and the Medicaid Fraud Control Unit (MFCU), any aspect of transportation service delivery, by any transportation services provider, any adverse or untoward incident.

7. **Revised 09/01/09: FCA shall have adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse. The compliance officer shall have unrestricted access to FCA's governing body for compliance reporting, including fraud and abuse.**

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8. Revised 09/01/09: FCA's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities.
9. Revised 09/01/09: FCA shall submit its compliance plan and its fraud and abuse policies and procedures to the Bureau of Medicaid Program Integrity (MPI) for written approval before implementation.
- a. At a minimum the compliance plan must include:
1. Written policies, procedures and standards of conduct that articulate FCA's commitment to comply with all applicable federal and state standards
 2. The designation of a compliance officer and a compliance committee accountable to senior management
 3. Effective training and education of the compliance officer and FCA's employees
 4. Effective lines of communication between the compliance officer and FCA's employees
 5. Enforcement of standards through well-publicized disciplinary guidelines
 6. Provision for internal monitoring and auditing
 7. Provisions for prompt response to detected offenses and for development of corrective action initiatives
- b. At a minimum, FCA's fraud and abuse policies shall:
1. Ensure that all officers, directors, managers and employees know and understand the provisions of the health plan's fraud and abuse policies and procedures
 2. Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this contract. Nothing in this contract shall require that the health plan assure that non-participating providers are compliant with this contract or state and/or federal law, but the health plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected
 3. Describe the health plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols

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10. Processes and controls for prevention and detection of potential or suspected fraud and abuse will be maintained, including, but not limited to:
- a. Claims edits
 - b. Post-processing review of claims
 - c. Billing and coding audits
 - d. Provider profiling and credentialing, including a review process for claims that shall include Providers and nonparticipating providers who:
 1. Consistently demonstrate a pattern of submitting falsified encounter or service reports
 2. Consistently demonstrate a pattern of overstated reports or up-coded levels of service
 3. Alter, falsify or destroy clinical record documentation
 4. Make false statements relating to credentials
 5. Misrepresent medical information to justify Enrollee referrals
 6. Fail to render Medically Necessary Covered Services that they are obligated to provide according to their Provider contracts
 7. Charge Enrollees for Covered Services
 - e. Prior Authorization
 - f. Utilization Management program
 - g. Relevant Subcontract and Provider contract provisions
 - h. Pertinent provisions from the Provider handbook and the Member handbook.
 - i. **Revised 09/01/09: Standards for code of conduct**
11. Revised 01/01/08: Contain provisions for the confidential reporting of FCA violations to the Agency's MPI and other agencies as required by law
12. **Revised 09/01/09: Include provisions for the investigation and follow-up of any reports**
13. When possible protect to the fullest extent of the law the identities of individuals reporting acts of fraud and abuse.
14. Report any confirmed or suspected provider or enrollee Fraud and Abuse under state and/or federal law to **Revised 09/01/09: MPI within 15 calendar days of detection. Additionally, any final resolution reached by the health plan must include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter.**

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15. Ensure that the health plan and all providers and subcontractors, upon request and as required by state and/or federal law, shall:
- a. Make available to, **Revised 09/01/09: all authorized federal and state oversight agencies and their agents, including but not limited to the Agency and the Florida Attorney General, any and all administrative, financial and medical records and data relating to the delivery of items or services for which Medicaid monies are expended.**
 - b. **Revised 09/01/09: Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency and the Florida Attorney General, to any place of business and all medical records and data, as required by state and/or federal law. Access shall be during normal business hours, except under special circumstances when the Agency and the Florida Attorney General shall have after-hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances.**
16. **Revised 09/01/09: Ensure that FCA shall cooperate fully in any investigation by the Agency, MPI, MFCU or any subsequent legal action that may result from a Fraud and Abuse investigation.**
17. **Revised 09/01/09: Ensure that FCA does not retaliate against any individual who reports violations of FCA's fraud and abuse policies and procedures or suspected fraud and abuse.**
18. **Revised 09/01/09: Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610.**
19. Use the federal List of Excluded Individuals and Entities (LEIE), or its equivalent, to identify excluded parties during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. FCA shall not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs
20. Revised 01/01/08: Provide details about the following, as required by Section 6032 of the federal Deficit Reduction Act of 2005:
- a. The False Claim Act
 - b. Penalties for submitting false claims and statements
 - c. Whistleblower protections

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- d. The law's role in preventing and detecting fraud, waste and abuse
- e. Each person's responsibility relating to detection and prevention
- f. **Revised 09/01/09: The toll-free state telephone numbers for reporting fraud and abuse**
21. Revised 01/01/08: In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, FCA shall distribute written Fraud and Abuse policies to all employees. If the Health Plan has an employee handbook, it shall include specific information about Section 6032 of the federal Deficit Reduction Act of 2005, FCA's policies, and the rights of employees to be protected as whistleblowers.
22. Comply with all reporting requirements set forth in Reporting Requirements of the PSN Contract.
23. **Revised 09/01/09: FCA shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI.**
24. Revised 07/23/08: FCA shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this section, the FCA Compliance Officer shall be the point of contact for the PSN and the Agency's Medicaid Fraud and Abuse Liaison shall be the point of contact for the Agency.
25. Educate FCA staff and its Providers regarding the requirements pertaining to Fraud and abuse and how to identify and report suspected incidences. FCA's Provider Handbook shall include information pertaining to Fraud and Abuse.
26. Ensure that FCA's Contract Manager (Provider Relations) will coordinate with Shands Healthcare Corporate Compliance Office to ensure that all staff and Provider orientation and education materials, manual references, etc. reflect the appropriate, current requirements as outlined in this policy and the PSN Contract.