



VNSNY CHOICE HEALTH PLANS

FRAUD, WASTE & ABUSE

DETECTION MANUAL

Developed for use by VNSNY CHOICE Directors, Officers, Managers and Staff, including Claims, Underwriting, Member Services, Utilization and Care Management, Compliance, Grievance and Appeal and Investigative Personnel.

Revised August 2018

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TO REPORT SUSPECTED FRAUD, WASTE AND ABUSE:

Telephone: 1-888-634-1558

EthicsPoint Web Portal: www.vnsny.ethicspoint.com

Write to:

VNSNY CHOICE

Attn: Special Investigations Unit

220 East 42nd Street, 3rd Floor

New York, NY 10017

INTRODUCTION

Fraud, Waste and Abuse (FWA) is a significant concern for VNSNY CHOICE and the entire health insurance industry, including Medicare Advantage and Medicaid Managed Care programs.

The Centers for Medicare & Medicaid Services (CMS), the FBI, and National Health Care Anti-Fraud Association (NHCAA) all estimate that tens of billions of dollars are lost to health care fraud every year.

The New York State Office of the Medicaid Inspector General (OMIG) reported that in 2015 it recovered nearly \$339 million in improperly spent Medicaid funds. In FY2015, the federal government recovered \$2.4 billion in health care fraud cases.

As the costs of health care rise, FWA prevention and detection is critical to ensuring continued coverage for New Yorkers who rely on Medicare and Medicaid—3.4 million and 6.4 million enrollees, respectively, as of August 2016.

This Fraud, Waste and Abuse Detection Manual outlines how everyone at VNSNY CHOICE can do their part to address FWA, and describes the robust systems VNSNY CHOICE has in place, and in implementation, to detect and investigate FWA.

I. FRAUD, WASTE AND ABUSE – OVERVIEW

1. What is Fraud Waste and Abuse?

Fraud is an intentional deception, concealment or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.

Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.

Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.

Together, Fraud, Waste and Abuse are often referred to as **FWA**.

Examples of FWA include:

- **By Providers:**
 - Billing for services not provided;
 - Deliberately filing incorrect diagnoses;
 - Upcoding procedures to more complex services;
 - Propagating or failing to address quality of care issues;
 - Failure to maintain adequate medical records;
 - Unbundling services to increase revenue when a more appropriate code exists;
 - Misrepresenting services or dates of service;
 - Billing non-covered services as covered services;
 - Ineligible or excluded providers rendering services and billing under an eligible provider's identifier;
 - Providing and billing for unnecessary testing and services;
 - Making "cluster visits" (i.e., multiple visits within a short time);
 - An absence of routine care services;
 - Billing for more time (e.g., anesthesia, psychotherapy) than actually provided;
 - Duplicate billing of more than one insurer for the same patient;
 - Not crediting durable medical equipment (DME), supplies and prescription drugs back to the insurer when the original was not picked up;
 - Re-selling DME, supplies or prescription drugs when the items were not received by the patient and the insurer was not credited;
 - Diverting drugs from medically necessary use to illegal resale; or
 - Accepting or offering kickbacks and bribery.

- **By Members:**
 - Loaning a VNSNY CHOICE identification card for use by another person;
 - Altering the amount or date of service on a claim form or prescription receipt;
 - Fabricating claims;
 - Reselling items provided by the plan;
 - “Doctor shopping” (seeing several providers to obtain frequent drug prescriptions); or
 - Making excessive trips to the emergency room for narcotics.

- **By Non-Members:**
 - Using a stolen VNSNY CHOICE card to obtain medical services or prescriptions; or
 - Engaging in impermissible sales and marketing practices to steer potential members to or from VNSNY CHOICE plans.

- **By VNSNY CHOICE Employees:**
 - Creating claims;
 - Delaying assignment of a provider to reduce costs;
 - Failing to provide covered services to reduce costs;
 - Engaging in impermissible sales and marketing practices, such as using unapproved promotional materials, falsifying eligibility information, enrolling individuals without their knowledge or offering inducements to members and providers to join; or
 - Changing member or provider addresses to intercept payments.

II. REPORTING FRAUD, WASTE AND ABUSE

If any VNSNY CHOICE director, officer, manager or staff member, or any other person affiliated with VNSNY CHOICE, suspects FWA, that person is required to report the suspected FWA. A report of suspected FWA may be made directly to the Compliance Department Special Investigations Unit (SIU) via:

- **Compliance Hotline:** 1-888-634-1558
- **EthicsPoint Web Portal:** www.vnsny.ethicspoint.com
- **Mail:** VNSNY CHOICE, Attention: Special Investigations Unit, 220 East 42nd Street, 3rd Floor, New York, New York 10017

Anyone who reports FWA may do so anonymously. All information received or discovered will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., federal and state authorities, VNSNY Legal Department, Medical Directors and/or Senior Management).

VNSNY CHOICE has a strict policy of not retaliating against, or intimidating, anyone who in good faith reports suspected FWA or another compliance issue.

FWA referrals are received by the VNSNY CHOICE SIU through the reporting mechanisms described above, as well as other mechanisms including, but not limited to, verbal or written notification by:

- VNSNY CHOICE directors, officers, managers or other staff members;
- Providers, vendors, consultants, members, caregivers, or First-tier, Downstream and Related Entities (FDRs);
- Members of the public;
- Law enforcement or regulatory agencies;
- Google or other electronic news alerts;
- The Grievance & Appeals Department, which may identify FWA during the investigation of a grievance, complaint, or appeal;
- The Quality Management Department, which may identify FWA during the investigation of a quality of care concern;
- The Provider Network Development Department, which may identify FWA during the investigation of a provider complaint; or
- Other VNSNY CHOICE Departments, such as Medical Management and Pharmacy, involved in authorizing services or monitoring utilization by members.

III. APPLICABLE LAWS, STATUTES AND RESOURCES SUMMARY

Federal:

- The **False Claims Act (FCA)**, 31 U.S.C. § 3729–33, as amended, provides for civil actions by the United States government to recover damages and impose civil penalties for false claims for payment. The *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)–(h), authorize private citizens, acting as whistleblowers and designated as relators, to initiate FCA actions to benefit the federal government and to share in any recoveries. Individuals and businesses that “knowingly” submit false claims or fraudulent documentation to the federal government can be liable for damages and civil penalties. The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. The two largest categories of federal funding programs represented in FCA actions are health care and defense industry fraud. However, any fraudulent request for payment to the federal government or its agents, or to states where the program at issue is partially funded by the federal government, can give rise to an FCA action.
- The **Deficit Reduction Act of 2005** places a greater emphasis on detecting and preventing FWA within the Medicaid program. Specifically, Section 6302 of the DRA, codified at 42 U.S.C. § 1396a(a)(68), requires any entities that pay or receive annual Medicaid payments of \$5 million or more to retain formal policies in combatting FWA for all employees.
- The federal **Anti-Kickback Statute (AKS)**, 42 U.S.C. § 1320a-7, is a criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of federal health care program business. The AKS is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the AKS results in mandatory exclusion from participation in federal health care programs and may also result in a fine of up to \$25,000 and imprisonment for up to five years. Absent a conviction, individuals who violate the AKS may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. The government may also assess civil monetary penalties, which could result in treble damages plus \$50,000 for each violation of the AKS. Although the AKS does not afford a private right of action, the FCA provides a vehicle whereby individuals may bring *qui tam* actions alleging violations of the AKS. When a private citizen sues on behalf of the federal government and is successful, they receive a percentage of the ultimate recovery for their “whistleblower” efforts.
- The **Stark Law**, 42 U.S.C. § 1395nn, prohibits physician referrals of health services for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that entity. A financial relationship includes ownership, an investment interest, or a compensation arrangement. Referral services may include clinical laboratory tests; physical therapy services; radiology and ultrasound services; radiation therapy services and supplies; DME and supplies; home

health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.

- **The Affordable Care Act** requires providers, Medicare Advantage Plans and Part D (Prescription Drug) Plans to report and return any overpayments within 60 days of discovery.
- The **Health Care Fraud Statute**, 18 U.S.C. § 1347, prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
- The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, as amended, provides privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other providers.
- **CMS** requires insurers to maintain a Compliance program that includes measures to detect and prevent FWA.
- The **Health Care Fraud Prevention and Enforcement Action Team (HEAT)** was established by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force, which successfully fights fraud.
- Pursuant to the **Exclusion Statute**, 42 U.S.C. § 1320a-7, the HHS **Office of Inspector General (OIG)** must exclude from participation in all federal health care programs any provider or supplier convicted of:
 - Medicare fraud;
 - Patient abuse or neglect;
 - Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service; or
 - Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds. Excluded providers cannot participate in federal health care programs for a designated period. An excluded provider may not bill federal health care programs (including, but not limited to, Medicare, Medicaid and State Children's Health Insurance Program [SCHIP]) for services he or she orders or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic.

New York State:

- The **New York State False Claims Act**, N.Y.S. Fin. Law §§ 187–194, allows the Attorney General or any other person to file a lawsuit against a person or a company that obtains or withholds funds or property from the state or local government through false or fraudulent conduct. A person or company found liable under the act must generally pay treble damages, civil penalties, plus costs and attorneys’ fees. Individuals who file suits may be eligible to keep a percentage of the funds they help recover. The state False Claims Act also protects employees from being retaliated against for filing *qui tam* suits against employers who may be engaged in activities or practices that defraud the government of money or property.
- The **Social Services Law**, at § 145-b, makes it a violation to knowingly obtain (or attempt to obtain) payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the Local Social Services District may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. A penalty of up to \$30,000 per violation may be imposed if repeat violations occur within five years and involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.
- The **Social Services Law**, at § 145-c, states that if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least \$1,000 but not more than \$3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of \$3,900), and five years for any subsequent occasion of any such offense.
- The **Penal Law Article**, at § 176, applies to claims for insurance payments, including Medicaid or other health insurance, and establishes six crimes ranging from Insurance Fraud in the 5th degree (a class A misdemeanor) through Insurance Fraud in the 1st degree (a class B felony). Furthermore, Aggravated Insurance Fraud (committing Insurance Fraud more than once) is a class D felony.
- **The Penal Law**, at § 177, addresses health care providers, including any publicly or privately funded health insurance or managed care plan or contract, who defraud the system. It also includes crimes ranging from Health Care Fraud in the 5th degree (a class A misdemeanor) through Health Care Fraud in the 1st degree (a class B felony).

IV. INVESTIGATING FRAUD, WASTE AND ABUSE

A. Investigation Procedures

The SIU investigates all reports of suspected FWA in accordance with the VNSNY CHOICE Policies and Procedures on the Special Investigations Unit and Fraud Waste and Abuse, and the VNSNY Corporate Policy on Investigating Compliance Issues and Corrective Action Plans.

The SIU Manager reviews all reports of potential FWA (“allegations”) and determines—within two (2) weeks, or fourteen (14) calendar days, of receipt by the SIU—whether a case must be initiated.

If, during the timeframes set forth above, the SIU Manager determines that an allegation cannot be addressed by the SIU due to lack of resources, time or experience (e.g., provider/member collusion cases that require undercover and/or surveillance, or allegations of kickbacks or bribery), the case is referred to National Benefit Integrity Medicare Drug Integrity Contractor (“MEDIC”), the OMIG or another enforcement agency, as appropriate. In such instances, the referral is documented in the SIU Database, and the case is closed. For referred cases, the SIU promptly responds to any follow up required by MEDIC, the OMIG or any other enforcement agency, and logs its response in the associated case file. In the event that a regulatory or law enforcement agency returns a case to the SIU for investigation, the case is reopened and responded to in accordance with applicable state and federal laws and VNSNY policies and procedures.

If the SIU Manager determines that a case must be initiated in response to an allegation, an investigation is commenced within three (3) business days following the opening of a case. Once a case is opened, the SIU Manager assigns the investigation to an Investigator. The Investigator logs the case in the SIU Database, noting the date the report was received, and establishes a case file (Note: In the case of FWA referrals from the Grievance & Appeals Department, the Grievance & Appeals Department provides the member or member representative with acknowledgment of receipt and notice of referral to the SIU.)

The Investigator researches the validity of the report, obtains all necessary supporting documentation for the case file and analyzes this documentation. Such activities may include:

- Three year review, if applicable, of provider or member claims history;
- Review of billing and/or payment history or patterns;
- Review of prescribing/ordering history;
- Provider malpractice, sanctions and exclusions checks;
- Review of medical records;
- Interviews with providers and/or members;
- Review of prior cases involving the provider or member;
- Review of provider and/or member contacts with VNSNY CHOICE; and
- Request for assistance from VNSNY CHOICE Operational areas.

Only information that is factual and pertinent to the case is gathered during the course of an investigation.

The Investigator and SIU Manager meet weekly to discuss and update cases. Some cases may require more extensive follow-up due to the complexity of the investigation and/or the timeliness of individuals' or entities' responses to requests for additional information or refunds. In all cases, however, the Investigator makes best efforts to update any investigation, if possible, every thirty (30) days following receipt of any allegation.

B. Reporting to Federal and State Agencies

The SIU notifies applicable federal and state agencies, and law enforcement as appropriate, of suspected FWA. Notified agencies may include OIG, the OMIG, MEDIC, or the New York State Medicaid Fraud Control Unit (MFCU).

These agencies provide specific forms and/or contact information for notification of suspected FWA. MFCU and the OMIG provide referral forms that can be transmitted by e-mail and toll free phone numbers; MEDIC supplies a referral form and a fax number; and OIG provides fax and phone numbers as well as an address for written complaints.

If during the course of an investigation the SIU determines that potential FWA or other misconduct has occurred, the SIU reports that misconduct to the appropriate agency (MEDIC, the OMIG, OIG or MFCU) within seven (7) days, but no later than sixty (60) days, if appropriate, after the determination that a violation may have occurred. If potential FWA or other misconduct is discovered at the FDR Level, the SIU refers the conduct to the appropriate agency (or agencies) within seven (7) days, so that notified agencies can help identify and address any scams or schemes.

If the SIU reports any FWA or other misconduct to an agency, that activity is reported to all other appropriate agencies at the same time. In all instances where a case is referred to an agency, the SIU continues to work the active investigation unless instructed otherwise.

For each case of FWA confirmed by the SIU, the VNSNY CHOICE Compliance Department reports to DOH the following information:

- The name of the individual or entity that committed the FWA;
- The source that identified the FWA;
- The type of provider, entity or organization that committed the FWA;
- A description of the FWA;
- The approximate range of dollars involved;
- The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data/information as prescribed by NYSDOH.

The Compliance Department files an annual report with DOH no later than January 15 of each year, describing VNSNY CHOICE's experience, performance and efficiency

in implementing its FWA prevention plan and proposals for improving this plan.

V. PROACTIVE DETECTION OF FRAUD, WASTE AND ABUSE

VNSNY CHOICE devotes significant resources and effort to proactive detection of potential FWA, and—as listed below—has developed key initiatives and processes aimed at proactively detecting patterns and practices of FWA.

- VNSNY CHOICE performs a service verification process, including telephonic outreach, on a quarterly basis. Through this process, a statistically significant sample of members with claims for recent dates of service are analyzed to confirm they received medical services billed and to trigger follow-up investigation by the SIU as appropriate.
- VNSNY CHOICE uses Medicare National Correct Coding Initiative claim coding edits to identify waste and to prevent improper payments.
- The SIU employs advanced analytics—specifically, the SAS statistical analysis system—in conjunction with the VNSNY CHOICE Data Warehouse to evaluate outliers and potential FWA patterns.
- The SIU conducts education and awareness training efforts to maximize suspected FWA referrals from directors, officers, managers, other staff members, contractors, agents, providers and FDRs. These efforts are further described in the following section.
- The SIU utilizes PLATO, a new tool developed by MEDIC, to identify and analyze aberrant trends.

VNSNY CHOICE has also implemented a Service Verification Process (SVP) to verify with its members that services billed by providers were actually received. On a quarterly basis, the SVP verifies the delivery of billed services to VNSNY CHOICE's members by pulling statistically valid claims samples and contacting members to confirm that services billed were in fact received. When members report that billed services were not received, the SIU investigates and takes appropriate corrective action, as necessary.

To track SVP activities, the VNSNY CHOICE Compliance Department has loaded the SVP as an “indicator” into its Online Monitoring Tool (OMT), which notifies the Business Intelligence & Analytics Department to generate the report, pull the sample described above and give feedback on both the claims chosen and the number of members identified for outreach. A second OMT indicator has been set up for the VNSNY CHOICE Call Center to provide a call outcome report with the number of members reached and the results of outreach with the members. The indicator also records any follow-up activities by the SIU, including notations on investigations opened based on the SVP calls.

VI. AWARENESS AND EDUCATION

VNSNY CHOICE employs a variety of approaches to promote the awareness and the education of employees and delegated entities about FWA:

- The VNSNY CHOICE website includes an FWA webpage accessible and publicized to directors, officers, managers, other staff members, FDRs, members, providers and the public. The webpage provides information about trends and hot topics in FWA, tips on how to detect FWA and information on reporting. Examples of content include news about recent fraud schemes and advice to members to review their Explanation of Benefits and report any services they should have but did not receive.
- FDRs that perform operational services on behalf of VNSNY CHOICE, including the pharmacy benefits manager and third-party administrator, attest yearly that they have provided FWA training to their employees and contractors.
- The SIU works with FDRs' special investigation units and audit departments to investigate FWA reports, to share information about individual cases or fraud schemes of common concern and to coordinate responses when potential trends or patterns are identified.
- The VNSNY CHOICE Compliance Department and the SIU perform formal and informal trainings throughout the year. Through a Compliance Awareness Campaign, the Department introduced its enhanced Compliance Program and Code of Conduct and led training and awareness events at all VNSNY locations, with specific content on FWA, including reporting and detection. Compliance Awareness Day includes multiple FWA awareness and training communications as well as in-person events.
- The Compliance Department and leadership maintain an open-door policy to communicate compliance concerns, suspected Code of Conduct violations and suspected FWA. This open-door policy is emphasized at every training opportunity.

SIU staff receive specialized training on investigation techniques and VNSNY systems, including SAS and the Data Warehouse, and they attend national conferences on the latest developments in Compliance and FWA. Investigators are expected to attend NHCAA (and/or other organizational) education and training programs, and to attend other conferences to monitor recent developments and strengthen coordination with law enforcement agencies.

VII. COMPLIANCE COMMITTEE AND REPORTING TO BOARD

On a quarterly basis, the SIU reports on FWA and its investigation activities (including trends, patterns, outcomes, corrective actions, and recoupment) to the VNSNY CHOICE Compliance Committee. FWA issues are also reported to the Audit Committee of the VNSNY Board of Directors as well as the VNSNY CHOICE Board of Directors. Such reporting includes the financial impact of claims issues investigated, as well as the estimated savings to VNSNY CHOICE due to changes in billing behavior in response to SIU actions.

The VNSNY CHOICE Fraud Plan is submitted to the Audit Committee of the VNSNY Board of Directors annually for review.

VIII. COLLABORATION WITH LAW ENFORCEMENT AND OTHER HEALTH PLANS

SIU staff are in regular contact with the OMIG at the investigative level to report suspected FWA and to coordinate on an ongoing basis regarding investigations and audits. SIU staff similarly have regular contact with the MEDIC to report and coordinate on reports and investigations of suspected FWA. SIU staff also attend New York task force events to share information on patterns and trends of FWA, and to establish further contacts with law enforcement, as well as other health plans. The SIU coordinates with other health plans' special investigation units to share information on investigations, particularly when a scheme common to the plans' vendors or providers is suspected.

IX. EXCLUSIONS CHECKS AND RELATED MONITORING

VNSNY CHOICE performs monthly checks of all employees against exclusionary lists to ensure that it does not hire or employ persons who have committed FWA or present a program integrity concern. These exclusionary lists include, as appropriate:

- The List of Excluded Individuals and Entities;
- The Excluded Parties System / System for Award Management;
- The Social Security Administration Death Master File;
- The National Plan Provide Enumeration System;
- The OMIG List of Restricted, Terminated or Excluded Individuals or Entities;
- The OIG Most Wanted Fugitives List;
- The Office of Foreign Assets Control – Specially Designated Nationals List;
- The New York State Office of the Professions Misconduct Enforcement System; and
- The New York State Office of Professional Medical Conduct Misconduct Enforcement System

Any checks that raise a potential concern or that involve a question of correct identity are escalated to VNSNY Corporate Compliance.

VNSNY CHOICE also checks new providers and re-enrolled providers, and performs monthly verifications on all participating providers, against excluded provider lists including those listed above. All network providers are required by contract to monitor staff and managers against the aforementioned exclusionary lists and to report any exclusions to VNSNY CHOICE on a monthly basis. Potential issues identified by provider checks are monitored through reports to the CHOICE Compliance Department and the SIU.

VNSNY CHOICE collects ownership and control disclosure information from managing employees for conflict of interest purposes.

X. FRAUD and ABUSE RESOURCES

Federal:

• HHS	www.hhs.gov
• CMS	www.cms.gov
• HEAT Task Force	www.stopmedicarefraud.gov
• OIG	www.oig.hhs.gov
• DEA	www.dea.gov
• DOJ	www.justice.gov
• MEDIC	www.healthintegrity.org
• Healthcare Fraud Prevention Partnership	www.hfpp.cms.gov
• FBI	www.fbi.gov

New York State:

• OMIG	www.omig.ny.gov
• MFCU	www.ag.ny.gov/bureau/medicaid-fraud-control-unit
• NYS Attorney General	www.ag.ny.gov
• NYS Physician Profile	www.nydoctorprofile.com
• NYS Professional Misconduct	www.op.nysed.gov/opd
• NYS Department of Health	www.health.ny.gov
• NYS Department of Financial Services	www.dfs.ny.gov

Private organizations:

• NHCAA	www.nhcaa.org
• ACFE	www.acfe.com
• Coalition Against Insurance Fraud	www.insurancefraud.org