SOUTH FLORIDA
COMMUNITY CARE NETWORK
BROWARD HEALTH & MEMORIAL HEALTHCARE SYSTEM

SFCCN Anti-Fraud Plan
MMA 2015-2016

Table of Contents

Table of Contents	**2**
Introduction	**3**
Elements of the Anti-Fraud Plan	**3**
Fraud and Abuse Definitions	**3**
SFCCN Administration and Management	**4**
Role of the Investigative Unit	**4**
Detection tools	**6**
Fraud and Abuse Reporting	**7**
Federal and State Oversight Agencies	**9**
Compliance Training	**9**
Exclusion Database Monitoring	**10**
Credentialing and Contracting	**10**
Attachment A	**11**
Attachment B	**12**
Attachment C	**15**
Attachment D	**16**

Introduction:
South Florida Community Care Network (SFCCN) is committed to detecting, investigating, and reporting instances of fraud and abuse committed by Medicaid members and providers and facilities. This Anti-Fraud plan meets Florida Statute 409.91212 requirements and SFCCN contract requirements with the Agency for Health Care Administration. The adoption of this anti-fraud plan significantly advances the detection and prevention of fraud and abuse, while at the same time furthers the fundamental mission of SFCCN to provide the highest quality services to our Medicaid enrollees.

Anti-Fraud Plan key elements:
- Internal detection of fraud and abuse;
- Investigation and prevention of fraud and abuse;
- Process for reporting fraud and abuse concerns;
- Development of auditing and monitoring system;
- Education and training; and
- Contact Person/Organizational chart.

Definitions:
Fraud:
An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Examples of Provider Fraud:
- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Upcoding the level of service provided; and
- Having an unlicensed person perform services that only a licensed professional is permitted to perform.

Abuse: Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid Program.

Examples of Provider Abuse:
- Overutilization of health care services;
- Provider billing irregularities; and
- Inaccurate coding.

Examples of Member Abuse:
- Residing out of state;
- Using another person’s Medicaid card;
- Doctor shopping for narcotic prescriptions; and
- Altered prescriptions.

Complaint: An allegation that fraud and abuse or an overpayment has occurred.

Medical Necessity: Health care services that a physician, exercising prudent, clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Overpayment: Overpayment defined in accordance with s. 409.913 F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

SFCCN Administration and Management:
The SFCCN Chief Compliance Officer oversees and upholds all fraud and abuse control activities within SFCCN, and has the overall responsibility for managing and carrying out the SFCCN Anti-Fraud Plan. The Chief Compliance Officer has unrestricted access, and reports on a quarterly basis to the Audit and Compliance Committee of the SFCCN Member Board. (Refer to Attachment A, Organizational Chart.)

The Chief Compliance Officer oversees the SFCCN Special Investigations Unit (SIU). The SIU Manager is responsible for the detection, investigation, and prevention of member and CMS provider fraud and abuse. The SIU consists of the SIU Manager/Fraud investigator, and a Clinical Reviewer. SFCCN SIU is also responsible for reporting suspected fraud and abuse by non-participating providers when detected. The SIU has ad hoc representation from the compliance departments of all SFCCN delegated providers (dental, behavioral health, vision, and transportation) with the expectation of compliance with SFCCN policies, as well as provider education regarding fraud and abuse prevention and detection. The SFCCN SIU Manager and the Clinical Reviewer report to the Chief Compliance Officer.

SFCCN's Chief Compliance Officer contact information:
Evan Sade
1643 Harrison Parkway
Suite 200, Building H
Sunrise, FL 33323
Phone (954) 622-3234
Fax (954) 417-7022
Email: esade@sfccn.org

Role of SFCCN Special Investigations Unit:
The SFCCN Audit and Compliance Committee has authorized the Chief Compliance Officer and the SIU Manager with the responsibility for fraud and abuse (as well as overpayment), detection, investigation and prevention.

The SIU is located in Sunrise, Florida, and consists of the Chief Compliance Officer, the SIU Manager/Investigator, and a Clinical Reviewer.

The SFCCN Compliance Officer is responsible for implementing, reviewing and approving all fraud and abuse and compliance protocols. These protocols include but are not limited to:

1. Quarterly Audit and Compliance Committee meetings;

2. Employee and provider training;
3. Internal and external detection, investigation and prevention of fraud and abuse;
4. Development of auditing and monitoring system; and
5. Corrective action process for correcting identified problems

The SFCCN Chief Compliance Officer is responsible for overseeing the SIU and its administration of the SFCCN Anti-Fraud Plan, including the implementation of internal controls and procedures for detecting, investigating and preventing acts of member and provider fraud and abuse. The SIU detects member and provider fraud and abuse based on receiving complaints from members, referrals from internal SFCCN staff, and by performing claims data analysis. When fraud and abuse is detected the SIU department initiates fraud and abuse investigations that may result in provider claim recoupments and fraud and abuse referrals to MPI, and the Medicaid Fraud Control Unit (MFCU). The SFCCN SIU manager and the SFCCN Chief Compliance Officer report all SIU activities and findings to AHCA MPI within contractual timeframes. The SFCCN SIU is committed to detecting, investigating and reporting suspected cases of fraud and abuse that have or might result in unnecessary costs to the Medicaid plan.

The following positions are responsible for carrying out SFCCN's fraud and abuse prevention strategy:

Chief Compliance Officer
Responsible for:

- Overseeing and monitoring the implementation, and day-day management of the compliance plan;
- Overseeing the Special Investigations Unit;
- Managing SFCCN Anti-Fraud Plan and Compliance program;
- Reporting all compliance matters to SFCCN Audit and Compliance Committee;
- Reporting suspected or confirmed Fraud and Abuse to Compliance Officer, Agency for Health Care Administration, Medicaid Program Integrity (AHCA MPI);
- Establishing methods, such as audits, to improve the organizations efficiency and quality and to reduce the practice's vulnerability and exposure to fraud and abuse;
- Periodically revising the Compliance Plan after reviewing changes or additions to law, needs of the organization, and requirements of Medicaid;
- Developing, coordinating and leading a compliance and HIPAA privacy training program;
- Screening network providers and new and existing employees and independent contractors against Federal exclusion databases to ensure they are authorized to participate in activities involving State and Federal health care programs;
- Investigating reports and allegations regarding possible unethical or inappropriate business practices;
- Monitoring subsequent corrective action and/or compliance;
- Reviewing compliance risk assessments; and
- Creating compliance dashboards, scorecards, self-assessment tools, and other evaluative tools.

SIU Manager/Investigator
Responsible for:

- Managing all aspects of SIU operations in its role of detecting fraud and abuse by members and providers;
- Working and communicating effectively with providers, members, staff, and witnesses;
- Obtaining written or oral statements, including medical reports and records, as may be required;
- Conducting internal investigations as requested by the Chief Compliance Officer;
- Training staff in SFCCN policy and procedures and investigative techniques;

- Investigating allegations and issues pertaining to potential health care fraud by members or providers;
- Generating leads for fraud investigations, reviewing claims data and member medical records to detect fraudulent activity;
- Documenting investigations, including preliminary and final case reports for both internal tracking and regulatory reporting purposes;
- Preparing cases for referral to State and Federal agencies; and
- Coordinating with internal departments to further fraud investigations, including periodic review of claims and supporting documents to enhance fraud detection, and to increase the likelihood of successfully resolving issues of overpayments and fraud and abuse activities.

Clinical Reviewer
Responsible for:

- Reviewing member medical records to determine medical necessity, appropriateness, and quality of treatment.

Detection Tools:
SFCCN proactively conducts both prospective and retrospective fraud and abuse investigations to detect member and provider fraud and abuse using resources such as provider claims data analysis, member complaints, provider post payment medical chart reviews, and tips received from internal SFCCN departments including medical management and quality management. Allegations of fraud and abuse can also be reported directly to the SFCCN Chief Compliance Officer using the SFCCN Compliance hotline.

SFCCN in collaboration with its software vendor, PSG Software, Virtual Examiner, has established integrated audit reports for use in the detection and identification of potential fraudulent claims. On a daily basis adjusted paid claims data is loaded into PSG Software, Virtual Examiner for review and processing by the SIU investigators. The system generates detailed integrated audit reports that identify potential fraudulent claim coding and billing which may require further review. The SIU Manager in collaboration with the Chief Compliance Officer determine if a claims investigation should be initiated.

In addition to the post payment review of claims using PSG Software, Virtual Examiner, the claims specialists in the Claims Department review all pended claims in the claim payment system (Tapestry). Pending claims include any claim that is not paid automatically by the claims system and therefore requires intervention by a claims department employee prior to payment. During a pending claim review, the claims specialists will forward any potentially fraudulent claims to the SIU Manager for further investigation. Potentially fraudulent claims include claims that may involve up-coding, unbundling, suspicious or unusual procedures, duplicate or potentially unnecessary procedures, etc. After receiving a potentially fraudulent claim from the Claims Department, the SIU Manager will initiate a claims investigation. During the claims investigation the SIU Manager will request records from the provider in-order to initiate a chart review. Chart reviews are completed by a licensed registered nurse and/or a certified coder and include meeting with a medical director to review the medical necessity of the procedures/services provided by the provider. The SIU Manager will report the status of all ongoing investigations as well as the resolution of any investigations which have concluded to the Chief Compliance Officer who will manage the reporting of the information to the Agency.

Refer to attachment B - Investigation process

Refer to attachment C - Flow chart of investigation process

Fraud and Abuse Reporting:
SFCCN's Chief Compliance Officer reports all suspected or confirmed instances of internal and external fraud and abuse related to the provision of, and payment for, Medicaid services within (15) calendar days of detection as specified in s. 409.91212, F.S. The online report can be found at: https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx.

The report shall contain at a minimum:

For Enrollees:
a) The name of the Enrollee;
b) The Enrollee's Medicaid identification number;
c) A description of the suspected fraudulent act; and
d) A narrative report of the suspected fraudulent act.

For Providers:
a) The name of the Provider;
b) The Provider's Medicaid identification number;
c) The Provider's tax identification number;
d) A description of the Provider's suspected fraudulent act; and
e) A narrative report of the suspected fraudulent act.

For Employees:
a) The name of Employee;
b) The Employee's organization ID Number;
c) A description of the suspected fraudulent act; and
d) A narrative report of the suspected fraudulent act.

On a quarterly basis SFCCN submits a comprehensive fraud and abuse prevention activity report regarding investigation, prevention, and detection activity efforts to AHCA MPI. In addition, by September 1, of each year SFCCN reports to MPI its experience in implementing an anti-fraud plan, and, on conducting investigations of possible fraudulent or abusive acts during the prior state fiscal year. The report contains, at a minimum;

1. The dollar amount of health plan losses and recoveries attributable to overpayment, abuse and fraud;
2. The number of SFCCN fraud and abuse referrals to MPI during the prior year; and
3. The reporting is in addition to the quarterly MPI QFAAR.

SFCCN notifies U.S. Department of Health and Human Resources, Office of Inspector General (DHHS OIG) and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s. 1892 of the Social Security Act. 42 CFR 455.106, 42 CFR 1002.3, and 42CFR 1001.1.

SFCCN discloses to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
1. Has ownership or control interest in SFCCN, or is an agent of SFCCN; and
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or CMS Title XXI, or Title X1X programs.

Additionally, SFCCN discloses the identity of any person described in 42 CFR 1002.3 and 42 CFR 100.101 (a)(1) who has ownership or a controlling interest in an MMA or CMS plan participating provider, or subcontractor, or is an agent or managing employee of an MMA or CMS plan participating provider, or subcontractor, and meets at least one of the following requirements.

1. Has been convicted of a crime as identified in S. 1128 of the Social Security Act and/or convicted of a crime related to that person's involvement in any program under Medicare, Medicaid, or the CMS Title XIX or CMS Title XXI services program since the inception of those programs;

2. Has been denied entry into the CMS Plan's network for program integrity-related reasons; or

3. Is a provider against whom SFCCN has taken any action to limit the ability of the provider to participate in the CMS provider network, regardless of what such an action is called. This includes, but is not limited to suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or CMS plan provider network to avoid a formal sanction.

SFCCN submits the required written notification to DHHS OIG via email to: floridaexclusions@oig.hhs.gov and a copy to MPI via email to: mpifo@ahca.myflorida.com. Documentation examples include, court records, indictments, pleas agreements, judgments and conviction/sentencing documents.

Attention: Florida Exclusions
Office of the Inspector General
Office of Investigations
7175 Security Boulevard, Suite 210
Baltimore, MD 21244

With a copy to MPI at:
Attention: Florida Exclusions
Office of the Inspector General
Medicaid Program Integrity
2727 Mahan Drive, M.S. #6
Tallahassee, FL 32308-5403

Any fraud and abuse investigation final resolution, i.e., referral to CMS & MPI or a claim overpayment, reached by the SFCCN SIU department includes 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.

SFCCN recognizes that any individual (employee, enrollee, provider or contractor) may confidentially report suspected Medicaid fraud, waste, or abuse without fear of retaliation in one or more of the following ways:

- The SFCCN Compliance Hotline 1-855-843-1106
- SFCCN Chief Compliance Officer Phone: 954-622-3234
- The Florida Medicaid Program Integrity Fraud and Abuse Hotline at 888-419-3456
- The Department of Health and Human Services Office of the Inspector General (OIG) at 800-447-8477.
- The Florida Attorney General's Hotline for Reporting Medicaid Fraud at 866-966-7226

- Online by filling out the Medicaid Fraud and Abuse Compliant Form at: http://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

All compliance, and fraud and abuse reports submitted to the SFCCN compliance hotline are thoroughly investigated by the SFCCN Chief Compliance Officer, and corrective action plans are implemented if found to be necessary. The Chief Compliance Officer follows up with the individual who reported the issue as part of the compliance hotline investigation process.
Confidentiality is maintained for both the suspect individual or group, and the individual reporting the compliance issue or possible fraud and abuse. SFCCN does retaliate in any manner against any employee, enrollee, provider or contractor for reporting a compliance issue.

In such cases, SFCCN may not have knowledge of the reported fraudulent claim or act.

Federal and State Oversight Agencies:
SFCCN and all MMA providers and subcontractors are required to cooperate with and make available to federal and state oversight agencies and their agents including AHCA, Florida Attorney General and Florida Department of Financial Services, the following upon request:

- Any and all administrative, financial and medical case/records relating to the delivery of items or services for which Medicaid dollars are paid;
- Allow access to any place of business and all medical/case records and data as required by state and/or federal law; and
- Cooperate fully in any investigation and any subsequent legal action that may result from such an investigation.

Compliance Training:
The Chief Compliance Officer is responsible for conducting Annual Compliance and Fraud and Abuse training for all SFCCN employees, contractors and MMA network providers. Compliance and fraud and abuse training for providers is available on the SFCCN website (www.sfccn.org). In addition, SFCCN new hires receive compliance training from the Chief Compliance Officer within thirty (30) days of hire. The compliance training includes but is not limited to the following:

- The Federal False Claims Act;
- Section 6032 of the Deficit Reduction Act;
- The penalties and administrative remedies for submitting false claims and statements;
- Whistleblower Protection under federal and state law;
- The entities role in preventing and detecting fraud, waste and abuse;
- Each person's responsibility relating to detection and prevention;
- How to report fraud, waste, and abuse; and
- Toll Free state telephone numbers for reporting fraud and abuse.

The Chief Compliance Officer keeps a copy of the compliance training Statement of understanding and the signature log to verify training was completed.

Information regarding fraud, waste, and abuse is communicated to providers through various channels:

- Compliance training for providers is available on the SFCCN website;
- In the contract language for all contracted providers;
- Provider manual; and
- During credentialing and re-credentialing.

The Chief Compliance Officer is responsible for verification that employees, contractors and network providers complete the required fraud and abuse compliance training annually, and new employee and subcontractors complete the training within thirty days of hire. Currently, providers self-report completion of the fraud waste and abuse compliance training to SFCCN via email, fax or mail. SFCCN is implementing an electronic system that will allow us to monitor provider and subcontractor completion of the required fraud waste and abuse compliance training.

Exclusion Database Monitoring:
All SFCCN employees, contractors, vendors, and network providers are checked by SFCCN on a monthly basis in the following databases to ensure that they have not been excluded from participating in Medicare, Medicaid and any other Federal health care program: If it is determined that an employee or network provider has been suspended or debarred, the individual or entity shall be removed from the provider network and payments must be immediately stopped.

1. The Department of Health and Human Services, Office of Inspector General (OIG) list of excluded individuals and entities, List of Excluded Individuals and Entities (LEIE). The LEIE is available at the following link: http://exclusions.oig.hhs.gov/.

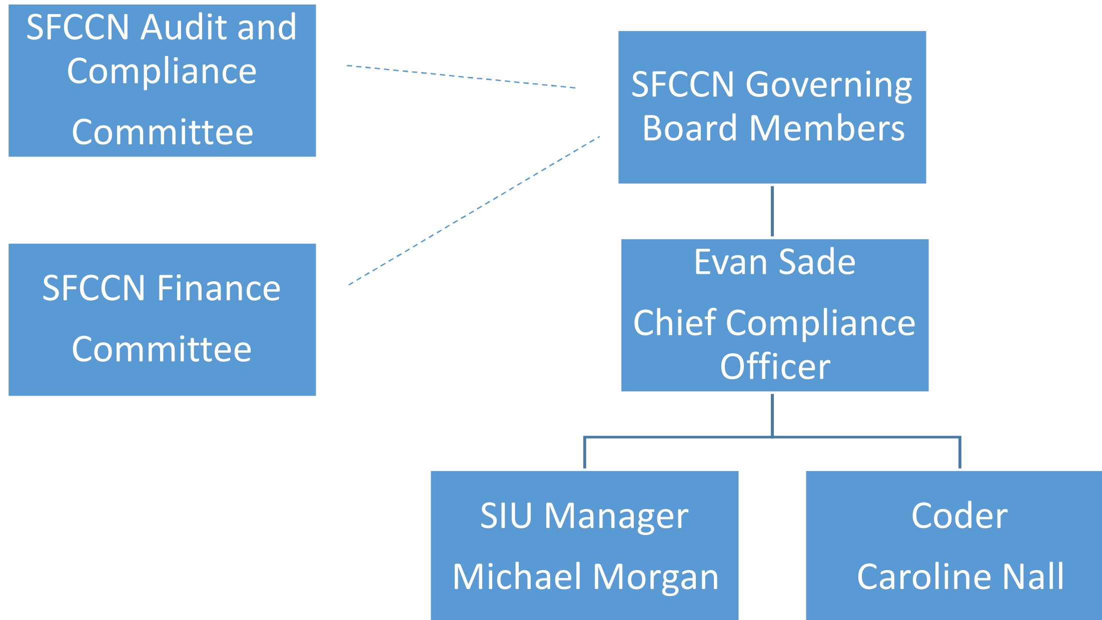
2. The General Services Administration (GSA) System for Award Management (SAM), SAM contains debarment actions taken by various federal agencies, including the OIG. including non-health care contractors with whom sponsors may not contract. The SAM is available at the following link: ttps://www.sam.gov/portal/public/SAM/. SAM is updated in real time.

3. Florida Agency for Health Care Administration (AHCA) list of Sanctioned, Terminated or Excluded Individuals or Entities.

The search results are kept in an electronic spreadsheet that is maintained by SFCCN's Chief Compliance Officer. SFCCN is not permitted to engage the services of any entity that is in non-payment status or is excluded from participating in federal health care programs under ss. 1128 and 1128A of the Social Security Act.

Credentialing and Contracting
The SFCCN credentialing/re-credentialing and contracting process play a critical role in helping prevent provider fraud and abuse. Credentialing and contracting serve as the gateway for physicians and other health care providers into the SFCCN Medicaid MMA provider network. All providers in Broward, Miami-Dade and Monroe County must go through SFCCN's detailed credentialing and contracting process prior to becoming a network provider. The SFCCN credentialing and contracting process is designed to ensure that network providers are eligible, qualified and meet the requirements to be SFCCN network providers. Refer to SFCCN Provider Credentialing and Recredentialing Policy No. CR1001.

Attachment A



Attachment B:

Investigation Process:

- New Investigations
  - Investigations can be initiated in several ways including referrals based on a complaint by a member or other person, internal referral form, internally developed based on proactive analysis or additional discoveries while investigating other cases.
    - All new investigations will be screened and prioritized by the SIU Manager in conjunction with the Chief Compliance Officer.

- All new investigations shall be reviewed and entered in case file. The case file will contain an initial note describing the investigation predication.

- Complaint Sourced Referrals
  - Within 15 calendar days of opening an Investigation, the complaint will be reported to MPI and/or any other agency that applies to the complaint status.

- Receipt and Assignment of Investigation
  - The investigator will review the file to determine the allegation(s) and document the plan of action in the case notes. The investigator is to assess any Medicaid exposure the provider may have across all lines of Medicaid (i.e. DME, Home Health, etc.) The plan of action must be established within 5 business days of investigation assignment.

- Proceeding with the Investigation
  - The SIU Manager shall complete a thorough background check on the organization and owners/officers to ensure no involved party is excluded from Medicaid participation or has been convicted of a felony. This can be done through the HHS OIG Exclusion Database and Division of Corporations search. All notes citing the results (to include all names) are to be entered into the case file.
  - Once a plan of action has been established, the investigator will proceed with the investigation development.
  - Additional development should include but is not be limited to:
- Association Check
- Advanced data analysis using Health Care Fraud Shield available to the investigator
- Internet Research
- Medicaid Policies and Regulations

- Through the evaluation of the information discovered in this development and by taking an investigative approach including activities such as provider interviews and on-site visits, the investigator will be expected to identify appropriate courses of action to protect the Medicaid Fund. The timely evaluation of the information discovered during case development and familiarity with development tools described above will aid in identifying appropriate administrative actions.

Development may include but are not limited to one or more of the following:

- Member Interviews
- Medical record review
- Overpayment
- Data review
- On-site visits
- Referral to AHCA Medicaid Program Integrity –MPI
- If member interviews are conducted in person, the investigator may:
  - Contact the member prior to the interview and receive the member's consent to conduct an in-person interview.
  - Present and provide a business card to the member.
  - Complete interview report
- Consult the guidelines for medical record review – necessary to verify services rendered and/or rendered as billed to the program.
  Prior to taking any action associated with a post-payment review to include requesting medical records.
- The investigator will maintain any notification letters returned from the post office in the files.

- If requesting records on a provider/supplier and it is necessary to obtain the records from the facility, the request to the facility for the records must contain a cc to the provider in question, unless informing the provider/supplier of the request to the facility would jeopardize the investigation. Keep in mind this depends on the nature of the investigation. Be sure to verify the appropriate discipline of the provider (i.e., MD, PhD, etc.). If medical records are not received within the requested thirty (30) calendar days, or fifteen (15) calendar days in the case of requests for medical records that are Complaint Sourced, and the provider/supplier still is located at the Medicaid address of record, send a second letter instructing the provider/supplier to submit the requested medical records within fifteen (15) calendar days. If the provider/supplier no longer is located at the address of record, or if the provider/supplier has not responded within fifteen (15) calendar days to the second request, discuss with management regarding the next appropriate action.

- Case notes must be updated minimally on monthly bases, showing progression of the investigation.

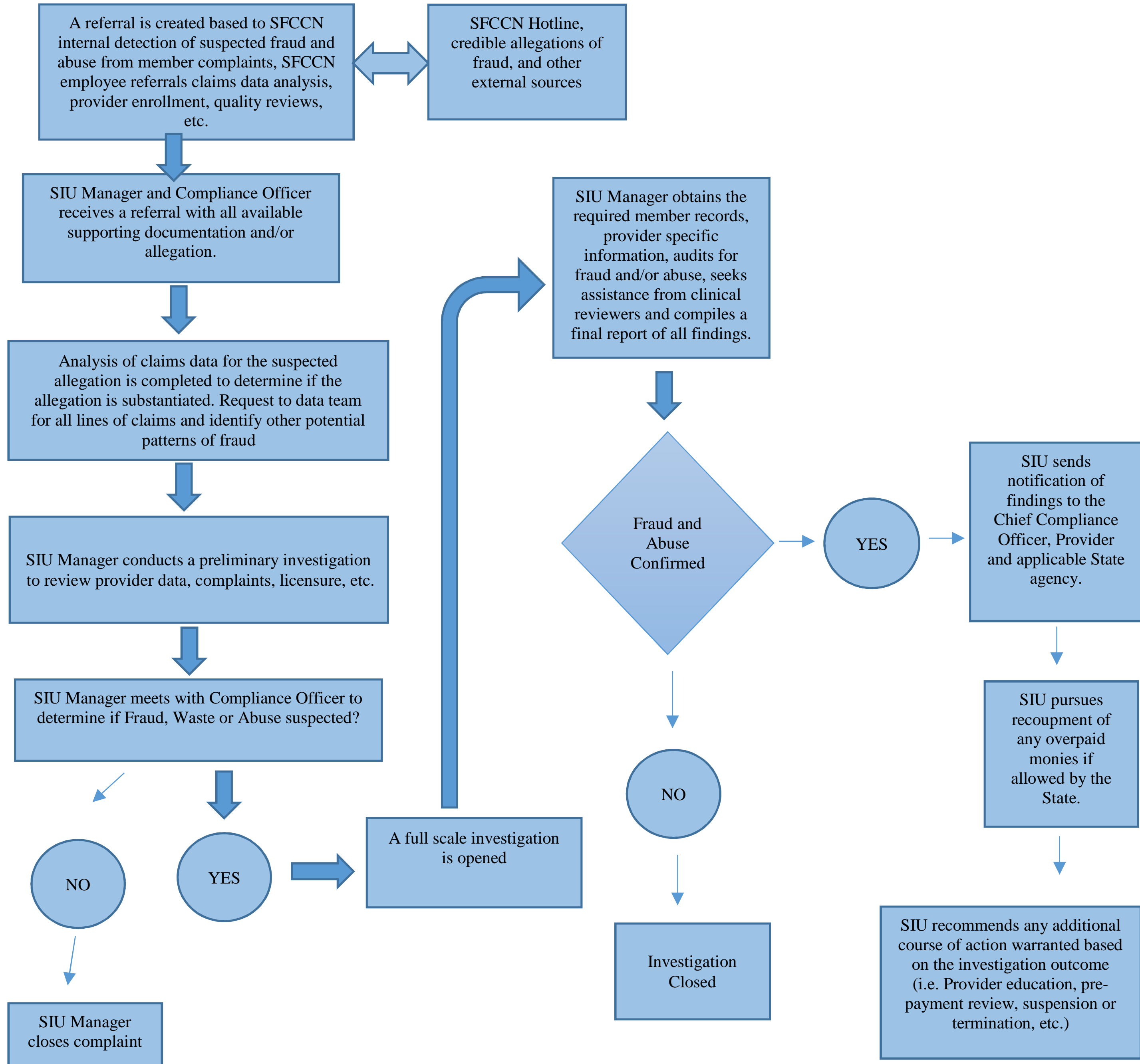
- After medical record review, onsite, and interview conducted, the Investigator will conclude the investigation with an Education Letter, Overpayment notice, or close with no findings.

- Resolution of the investigation should be done within 6 – 12 months. *There may be some investigations that may take longer to work, notes and documentation will address those special circumstances. (Notify MPI of outcome)

** This process is a general guide for an investigation, there may be times that the process will need to be changed.

Attachment C:

Internal Flow Chart from the First Point of Suspicious Activity through Reporting of fraud, waste and abuse.



Attachment D:
MPI – Annual Fraud and Abuse Activity Report for Title XIX

AHCA Contract Number	Health Plan Medicaid Provider #	# of Referrals to MPI	Total Overpayments Identified for Recovery	Total Overpayments Recovered	Total Dollars Identified as Lost to Fraud &	Total Dollars Lost to Fraud & Abuse that were Recovered	Notes
FP019	010833310	11	$0	$0	$0	$0	

#	Summary Overview
11	Total Cases Reported to the MPI
1	Open Cases
10	Closed Cases
5	Total Providers Reported
6	Total Member Reports
2	Total Provider Types Reported
5	Allegation Types

#	Provider Types Summary
	- Dentist (35)
	- Home Health Agency (65)
4	- Physician (M.D.) (25)
	- Therapist (83)

#	Allegation Types Summary
	Provider - Billing excessive services
1	Provider - Billing for services not rendered
1	Provider - Disenrollment issues
	Provider - Pattern of overstated reports (upcoding)
	Provider - Other, not operating within Medicaid guidelines
	Provider - Prior Authorization- Provider billing for non-covered/unauthorized services
	Member ID info missing on subsequent pages of note
	Some notes missing provider’s signature
	Undercoding
6	Member Related

This report is updated and reported annually by September 1