



**Community Care Plan (CCP)  
Anti-Fraud Plan  
MMA 2018-2019**

## **Table of Contents**

<b>Table of Contents</b>	<b>2</b>
<b>Introduction</b>	<b>3</b>
<b>Elements of the Anti-Fraud Plan</b>	<b>3</b>
<b>Fraud, Waste, and Abuse Definitions</b>	<b>3</b>
<b>CCP Administration and Management</b>	<b>4</b>
<b>Role of the Investigative Unit</b>	<b>5</b>
<b>Detection tools</b>	<b>8</b>
<b>Verifying enrollees' Identity and Verification of Rendered Services:</b>	<b>9</b>
<b>Fraud and Abuse Reporting</b>	<b>9</b>
<b>Federal and State Oversight Agencies</b>	<b>13</b>
<b>Compliance Training</b>	<b>13</b>
<b>Exclusion Database Monitoring</b>	<b>14</b>
<b>Credentialing/Re-credentialing, Provider Profiling and Ongoing Provider Monitoring</b>	<b>15</b>
<b>Utilization Management</b>	<b>16</b>
<b>Attachment A</b>	<b>17</b>
<b>Attachment B</b>	<b>18</b>
<b>Attachment C</b>	<b>21</b>
<b>Attachment D</b>	<b>22</b>

## **Introduction:**

Community Care Plan (CCP) is committed to detecting, investigating, and reporting instances of fraud, waste, and abuse (FWA) committed by Medicaid members and providers and facilities. This Anti-Fraud plan meets Florida Statute 409.912.12 requirements and CCP contract requirements with the Agency for Health Care Administration (AHCA). The adoption of this anti-fraud plan significantly advances the detection and prevention of fraud, waste, and abuse, while at the same time furthers the fundamental mission of CCP to provide the highest quality services to our Medicaid enrollees.

### **Anti-Fraud Plan key elements:**

- Internal detection of fraud, waste, and abuse.
- Investigation and prevention of fraud, waste, and abuse.
- Process for reporting fraud, waste and abuse concerns.
- Development of auditing and monitoring system.
- Education and training.
- 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
- Up-coding the level of service provided
- Having an unlicensed person perform services that only a licensed professional is permitted to perform.

**Waste:** Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to Medicaid or MMA. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

### **Examples of Provider Waste:**

- Ordering excessive laboratory tests such as a comprehensive metabolic panel or a group of blood tests when only one test is needed.
- Ordering Magnetic Resonance Imaging (MRI) instead of a mammogram for preventive care.

**Abuse:** Provider practices that are inconsistent with generally accepted business or medical practices 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.
- Inaccurate coding.

Examples of Member Abuse:

- Residing out of state.
- Using another person's Medicaid card.
- Doctor shopping for narcotic prescriptions.
- 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 evaluating, diagnosing or treating an illness, injury, disease or its symptoms, 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.
- Not primarily for the convenience of the patient or physician, and not costlier 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 Medicaid or MMA whether paid because of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Examples of Overpayment:

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits.
- Payment for non-covered items and services, including medically unnecessary services or custodial care furnished to a member.

**CCP Administration and Management:**

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

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

CCP's Compliance Officer contact information:

JoAnn McDaniel-Chinn

1643 Harrison Parkway

Suite 200, Building H

Sunrise, FL 33323

Phone (954) 622-3234

Fax (954) 417-7022

Email: [jmcdaniel-chinn@ccpcare.org](mailto:jmcdaniel-chinn@ccpcare.org)

### **Role of CCP Special Investigations Unit:**

The CCP Audit and Compliance Committee has authorized the Compliance Officer and the SIU Manager with the responsibility for FWA (as well as overpayment), detection, investigation, and prevention.

The SIU is in Sunrise, Florida, and consists of the Compliance Officer, the SIU Manager, Clinical Reviewer and a Quality Control Claims Auditor.

The CCP Compliance Officer is responsible for implementing, reviewing and approving all FWA 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, waste, and abuse.
4. Development of auditing and monitoring system.
5. Corrective action process for correcting identified problems.

The CCP Compliance Officer is responsible for overseeing the SIU and its administration of the CCP Anti-Fraud Plan, including the implementation of internal controls and procedures for detecting, investigating and preventing acts of member and provider FWA. The SIU detects member and provider FWA based on receiving complaints from members, referrals from internal CCP staff, and by performing claims data analysis. When FWA is detected the SIU initiates investigations that may result in provider claim recoupments and FWA referrals to Medicaid Program Integrity (MPI), and the Medicaid Fraud Control Unit (MFCU). The SIU Manager and the Compliance Officer report all SIU activities and findings to AHCA MPI within contractual timeframes. The CCP 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 CCP's FWA prevention strategy:

### Compliance Officer

Responsible for:

- Overseeing and monitoring the implementation, and day-to-day management of the compliance plan;
- Overseeing the Special Investigations Unit.
- Managing CCP's Anti-Fraud Plan and Compliance program.
- Reporting all compliance matters to CCP Audit and Compliance Committee.
- Reporting suspected or confirmed FWA to the AHCA, Medicaid Program Integrity (MPI).
- Establishing methods, such as audits, to improve the organization's efficiency and quality and to reduce the practice's vulnerability and exposure to FWA.
- 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.
- Creating compliance dashboards, scorecards, self-assessment tools, and other evaluative tools.

### SIU Manager

Responsible for:

- Managing all aspects of SIU operations in its role of detecting fraudulent activities by members, providers, and other parties against CCP.
- 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 Compliance Officer of the company.
- Training staff in CCP policy and procedures and investigative techniques.
- Investigating allegations and issues pertaining to potential health care fraud by providers or members.
- Generating leads for fraud investigations, reviewing claims data and member 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.

- 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 fraudulent activities.

#### Clinical Reviewer

Responsible for:

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

#### Quality Control Claims Auditor

Responsible for:

- Performing audits of and may adjudicate high dollar claims while maintaining acceptable levels of claims inventory and age.
- Ensuring claim payment accuracy by verifying various aspects of the claim including eligibility, system coding and pricing, pre-authorization, and medical necessity.
- Completes and maintains detailed documentation of audits which includes decision methodology, system or processing errors, and monetary discrepancies which are used for financial reporting and trending analysis.
- Provides feedback on processing errors; identifies quality improvement opportunities and initiates basic requests related to coding or system issues, where applicable.
- Refers overpayment opportunities to Claims Director.
- Work proactively with Director of Claims to ensure quality recommendations are made and implemented.
- Maintain thorough and complete knowledge of assigned functional processes to effectively evaluate accuracy levels.
- Responsible for pre and post payment claim auditing of medical records and associated clinical documentation to ensure proper charge capture, billing in accordance with standard billing policies and reimbursement principles.
- Responsible for assisting Claims Department and other departments with resolution of billing issues and/or denials requiring medical coding expertise, participating in external audit requests, and special projects as needed.
- Coordinates, conducts, and documents audits requested by outside agencies.
- Prepares written reports or trending data related to findings and facilitates sign off with leadership facilitates timely turnaround of audit results.
- Prepares written summaries of departmental audit results, which allow leadership the ability to monitor and manage their revenue capture and documentation processes
- Clearly state what is identified as a deficiency or error in work being reviewed.
- Makes recommendations for improvement of procedures, documentation, and revenue optimization opportunities.
- Retrieves and compiles data across multiple information systems and provides needed information for internal and external customers in a timely manner.
- Recommends and assists in audit and documentation policy changes/new policies as necessary to ensure compliance, accurate charging, and charge documentation.

- Identifies potential provider fraud through review of claims data, complaint referrals, and application of rules, healthcare coding practices, and fraud detection software.
- Reviews provider-billing practices to investigate claims data and compliance with State and Federal laws.
- Analyzes provider data and identifies erroneous or questionable billing practices.
- Interprets state and federal policies, Florida Medicaid, and contract requirements
- Determines and calculates overpayment/underpayment and collects overpayment.
- Shares information with staff and providers regarding rules, regulations, and Medicaid Program Manual Guidelines.
- Meet all deadlines (weekly/monthly/quarterly) for review of work.
- Communicates with fiscal staff to identify system errors or other issues

### **Detection Tools:**

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

CCP in collaboration with its software vendor, PSG Software, Virtual Examiner, has established integrated audit reports for use in the detection and identification of potentially fraudulent claims. Daily adjusted paid claims data is loaded into PSG Software, Virtual Examiner for review by the SIU Manager. 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 Compliance Officer determines if a claim 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 not paid automatically by the claim system and therefore require intervention by a claims department employee prior to payment. During a pending claim review, the claims specialist 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 reviewing 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 to initiate a chart review. Chart reviews are completed by a licensed registered nurse and/or a certified coder and include meeting with a CCP 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 Compliance Officer who will manage the reporting of the information to the Agency.

Refer to Attachment B – Investigation process

Refer to Attachment C – Flowchart of the investigation.



### **Verifying enrollees' Identity and Verification of Rendered Services:**

CCP has incorporated several methodologies for verifying services billed by providers were received by enrollees. On an on-going basis, CCP SIU, as part of provider FWA investigations contacts enrollees by telephone to verify services billed by the provider were received by the enrollee.

Additionally, CCP verifies home-based visits and services using our innovative Concierge Care Coordination (C3) model, which serves as the core of our enrollee care coordination efforts. Each CCP C3 team includes a registered nurse who performs on-going telephone calls, and in-home visits to CCP enrollees' in-order to verify that the enrollee is receiving every aspect of care that they need, including home health care services. If the enrollee is supposed to be receiving home health care visits and service, the nurse will verify that they are receiving the services. By having this on-going communication with enrollees, CCP C3 nurses can detect patterns of provider FWA including, non-rendered and up-coded services, falsified medical records, misrepresented medical information, and providers that are not rendering medically necessary covered services. All potential FWA detected by the CCP C3 nurses are immediately referred to the SIU for investigation.

Recognizing the potential for errors in billing and fraudulent activity around provider services rendered in the enrollee's home, CCP has engaged Tellus, LLC, to contract for its Electronic Visit Verification (EVV) product. Tellus, LLC, offers secure tracking, and control platforms for remote in-home enrollee visit verification, provider clock-in/clock-out using mobile app or IVR, and confirmation of provider, beneficiary, location, start/end times and, real time alerts and schedule deviations and digital signature collection.

CCP believes that our use of Tellus, LLC, for verification of enrollee identity and provider home visits will greatly reduce the instances of FWA.

### **Fraud and Abuse Reporting:**

CCP's Compliance Officer reports all suspected or confirmed instances of internal and external FWA related to the provision of, and payment for, Medicaid services within (15) calendar days of detection as specified in s. 438.608 and s.409.91212, F.S. The online report can be found at <https://apps.ahca.myflorida.com/mpa-complaintform/>

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 activity.
- d) A narrative report of the suspected fraudulent activity.
- e) If fraud, waste or abuse is suspected or confirmed.
- f) Date of detection by the plan.

- g) Recipient Medicaid number.
- h) Status of the case.

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 activity.
- e) A narrative report of the suspected fraudulent activity.
- f) If the fraud, waste or abuse is suspected or confirmed.
- g) Date of detection by the plan.
- h) Provider Medicaid number, Tax ID, and National Provider Identifier.
- i) Status of the case.
- j) Overpayment identified.
- k) Amount of overpayment identified.

For Employees:

- a) The name of Employee.
- b) The Employee's organization ID Number.
- c) A description of the suspected fraudulent activity.
- d) A narrative report of the suspected fraudulent activity.
- e) If the fraud, waste or abuse is suspected or confirmed.
- f) Date of detection by the plan.
- g) Status of the case.

On a quarterly basis, CCP submits a comprehensive FWA prevention activity report regarding the investigation and detection activity efforts to AHCA MPI. In addition, by September 1, of each year CCP 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 overpayments due to FWA.
2. The number of CCP FWA referrals to MPI during the prior year.
3. The number of cases opened and closed.

A summary of the results of the investigations of fraud, abuse, waste, or overpayment which were conducted during the previous year by the Managed Care Plan's fraud investigative unit. For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the State fiscal year that concluded immediately prior to the submission of this report. This summary shall include:

- Total number of cases opened;
- Total number of cases closed;
- Total number of cases that remain open as of the last day of the previous fiscal year;
- Total of overpayments identified for recovery which were identified as waste;
- Total amount of overpayments identified for recovery which were identified as fraud or abuse;

- Total amount of overpayments identified as waste which were recovered; and
- Total amount of overpayments identified as fraud or abuse that was recovered.

CCP 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.

CCP discloses to DHHS OIG, with a copy to MPI within five (5) business days after discovery, the identity of any person who:

1. Has ownership or control interest in CCP or is an agent of CCP.
2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or MMA.

Additionally, CCP discloses the identity of any person described in 42 CFR 1002.3 and 42 CFR 100.101 (a)(1) who has ownership or control interest in an MMA plan participating provider, or subcontractor, or is an agent or managing employee of an MMA 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 MMA program since the inception of those programs.
2. Has been denied entry into the MMA Plan's network for program integrity-related reasons.
3. Is a provider against whom CCP has taken any action to limit the ability of the provider to participate in CCP 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 MMA plan provider network to avoid a formal sanction.

CCP submits the required written notification to DHHS OIG via email to: [floridaexclusions@oig.hhs.gov](mailto:floridaexclusions@oig.hhs.gov) and a copy to MPI via email to [mpifo@ahca.myflorida.com](mailto: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 FWA resolution, i.e., referral to MMA & MPI or a claim overpayment, reached by the 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.

CCP 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 CCP Compliance Hotline 1-855-843-1106
- AHCA Consumer Complaint Hotline: (888) 419-3456
- Florida Attorney General Hotline: (866) 966-7226
- DHHS OIG Hotline: (800) 447-8477
- Online by filling out the Medicaid Fraud and Abuse Complaint Form (to report suspected fraud, waste and abuse in the Florida Medicaid system) at <https://apps.ahca.myflorida.com/mpi-complaintform/>

Through the USPS by mailing it to:

Program Administrator, Intake Unit  
Medicaid Program Integrity  
Agency for Health Care Administration  
2727 Mahan Drive, MS #6  
Tallahassee, Florida 32308

All compliance, FWA reports submitted to the CCP compliance hotline are thoroughly investigated by the CCP Compliance Officer, and corrective action plans are implemented if found to be necessary. The 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 FWA. CCP does retaliate in any manner against any employee, enrollee, provider or contractor for reporting a compliance issue.

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

### **Federal and State Oversight Agencies:**

CCP 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:

- 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.
- Cooperate fully in any investigation and any subsequent legal action that may result from such an investigation.

### **Compliance Training:**

The Compliance Officer is responsible for conducting Annual Compliance and Fraud, Waste and Abuse training for all CCP employees, contractors and MMA network providers. Compliance and FWA training for providers is available on the CCP website (<https://www.ccpcares.org/>). In addition, CCP new hires receive compliance training 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.
- Toll-free state telephone numbers for reporting fraud and abuse.
- How to report fraud, waste, and abuse.

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

Information regarding FWA is communicated to providers through various channels:

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

The Compliance Officer is responsible for verification that employees, contractors, and network providers complete the required fraud, waste, and abuse compliance training annually, and new employees and subcontractors complete the training within thirty (30) days of hire. Currently, providers self-report completion of the FWA compliance training to CCP via email, fax or mail.

CCP is implementing an electronic system that will allow us to monitor provider and subcontractor completion of the required FWA compliance training.

### **Exclusion Database Monitoring:**

All CCP employees, contractors, vendors, and network providers are checked by CCP monthly in the following databases to ensure that they have not been excluded from participating in Medicare, Medicaid, and any other Federal health care program:

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 which has non-health care contractors with whom sponsors may not contract. The SAM is available at the following link: <https://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.

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.

The search results are kept in an electronic spreadsheet that is maintained by CCP's Compliance Officer. CCP 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/Re-Credentialing, Provider Profiling, and Ongoing Provider Monitoring:**

The CCP credentialing/re-credentialing, provider profiling and ongoing provider monitoring process plays a critical role in helping prevent provider FWA. CCP credentialing and re-credentialing serves as the gateway for physicians and other health care providers into the CCP Medicaid provider network. All providers in CCP's Network must go through CCP's detailed credentialing and contracting process prior to becoming a network provider. The CCP credentialing/re-credentialing process is designed to ensure that network providers are eligible and qualified to be CCP network providers. As part of the credentialing/re-credentialing process CCP verifies the following:

- Verification of the providers current medical license or facility license;
- Verification of the providers highest levels of education;
- Verification that the provider has not had any Medicare/Medicaid and state sanction activities;

- Verification that the provider has not had a revocation, moratorium or suspension of state license by AHCA;
- Verification that the provider has an active Florida Medicaid provider number;
- Review of State of Florida disciplinary reports at least monthly, and at time of credentialing re-credentialing;
- Review of the providers profession liability claims history;
- Review of provider DEA registration;
- Review of good standing report on a site visit survey including evidence that CCP has evaluated the provider's facilities.

The CCP credentialing/re-credentialing criteria for all network providers are reviewed at least annually by the CCP credentialing committee, including procedures for forwarding all suspected FWA to the CCP SIU Department for investigation and reporting.

The CCP SIU performs provider profiling and ongoing monitoring of providers and non-participating providers including conducting claims and encounter data analysis looking for non-compliant coding, billing and encounter reporting by providers. CCP SIU closely monitors coding and billing submitted by provider types that have a high risk of FWA, including home health providers and physical and occupational therapy providers. Additional provider profiling of all CCP providers and non-participating providers is performed by CCP in-order to detect providers who:

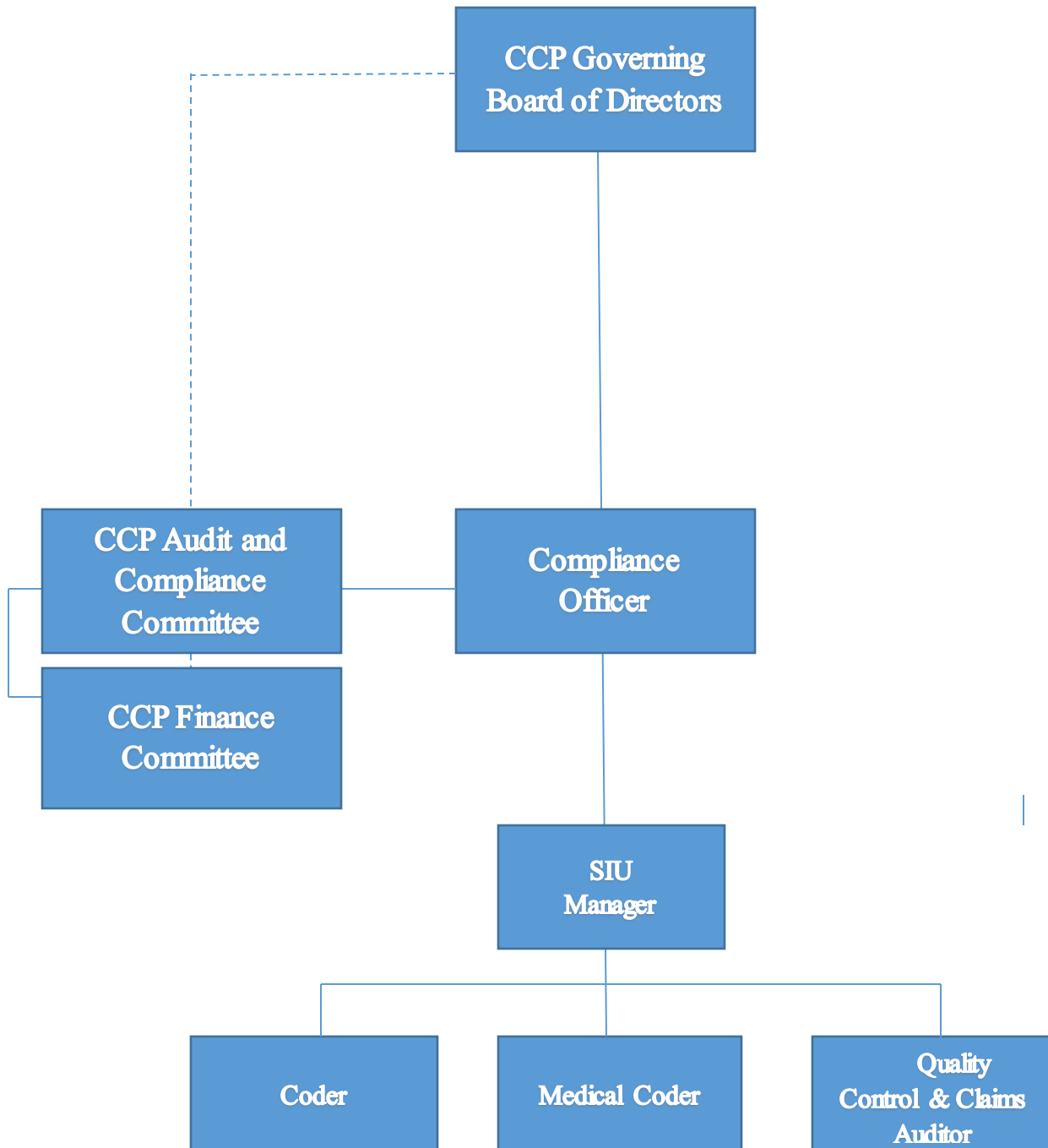
- Demonstrate a pattern of submitting falsified encounter data or service reports;
- Demonstrate a pattern of overstated reports or up-coded levels of service;
- Alter, falsify or destroy clinical record documentation;
- Make false statements related to credentials;
- Misrepresent medical information to justify enrollee referrals;
- Fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
- Charge enrollees for covered services;
- Bill for services not rendered.

### **Utilization Management:**

CCP averages over 1,700 requests for prior authorization for services per month. The purpose of prior authorization of enrollee services is to enable treatments and services to occur in an appropriate setting, by a participating provider, and to ensure that the services are medically necessary. The CCP Utilization Management staff refer all instances of FWA that they detect while performing their pre-authorization responsibilities to the CCP SIU. Common FWA

detected by the Utilization Management staff and referred to the SIU include requests for medical unnecessary services and falsification of medical record documentation.

**Attachment A**





## Attachment B

### Investigation Process

- New Investigations
  - ◆ Investigations can be initiated in several ways. Initiation may be but is not limited to the following: referrals from 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.
- All new investigations shall be reviewed and entered in the case file. In the initial note, enter a brief predication and the prioritization rationale provided by the manager that assigned the investigation.
- Complaint Sourced Referrals
  - ◆ Within 15 calendar days of suspicion or confirmation of fraud, waste, or abuse, the complaint should be reported to MPI and/or any other agency that applies to the complaint status.
- Receipt and Assignment of Investigation
  - ◆ The investigator reviews the file to determine the allegation(s) and documents the plan of action in the case notes. The investigator is to assess any Medicaid exposure the provider may have across all lines of business (i.e. DME, Home Health, etc.). The plan of action must be established before meeting with management within 5 business days of investigation assignment.
- Proceeding with the Investigation
  - ◆ The SIU Manager will complete a thorough background check on the organization and owners/officers to ensure no involved party is excluded from Medicaid participation. This is done through the HHS OIG Exclusion Database and Division of Corporations search. All notes citing the results (to include all names) are to be documented prior to the 5-day meeting and QC of the investigation.
  - ◆ Once a plan of action is established, proceed with the investigation development.
- Additional development should include but is not be limited to:
  - ◆ Association Check
  - ◆ Determine the relationship of the provider to Owner, Managing Partner, Registered Agent, etc.
  - ◆ Advanced data analysis using resources available to the investigator
  - ◆ Internet Research
  - ◆ Medicaid Policies and Regulations

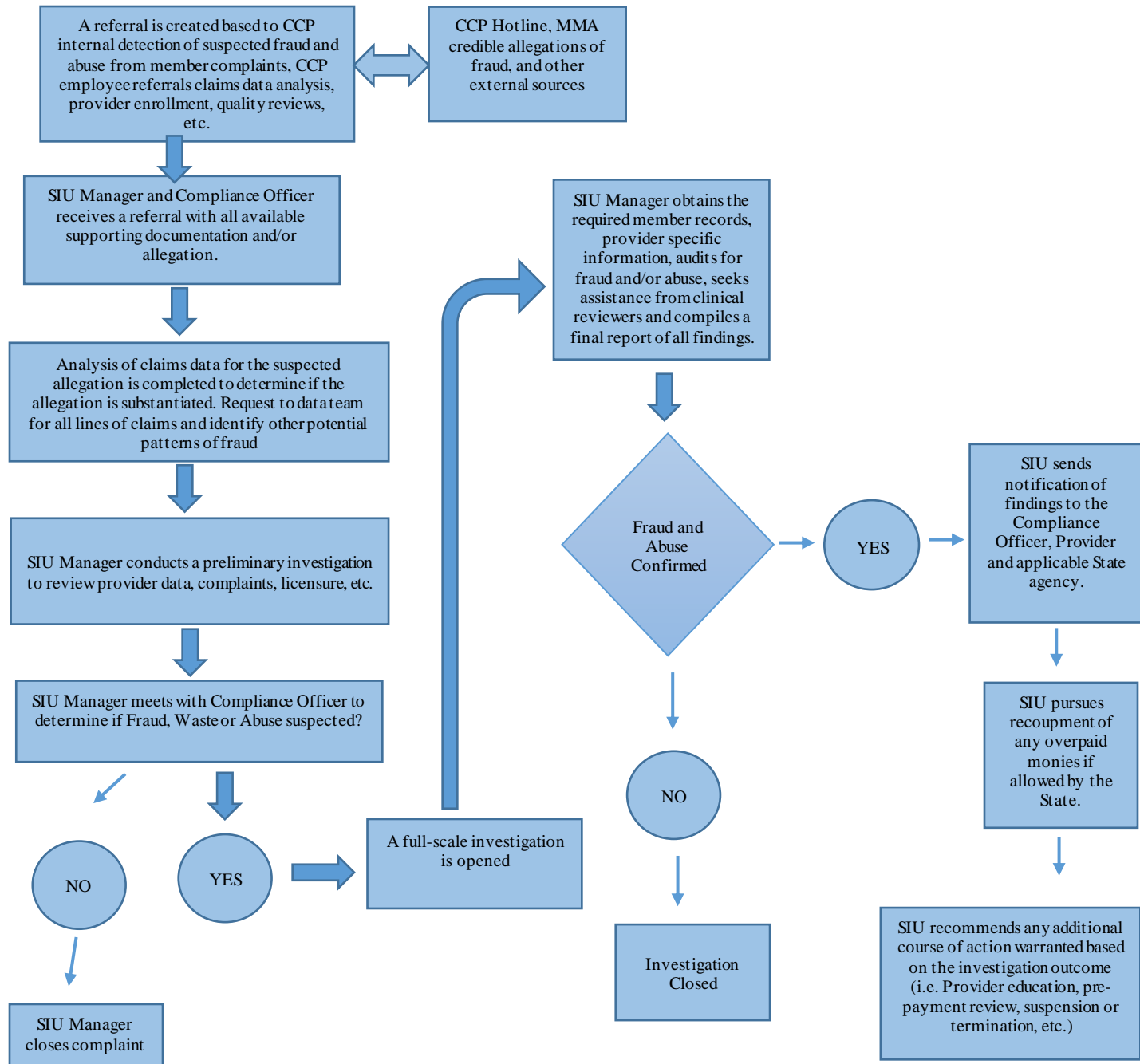
- ◆ Through the evaluation of the information discovered in this development and by taking an investigative approach including activities such as onsite and interviews, the investigator is expected to identify appropriate courses of action to protect Medicaid and MMA Plan funds. The timely evaluation of information discovered during case development and familiarity with development tools described above 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 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.
- When a medical review is part of the investigation, and before 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 (e.g., MD, Ph.D., 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 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 monthly, demonstrating the progression of the investigation.
- After the 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**

A summary of the results of the investigations of fraud, waste, abuse, or overpayment, which were conducted during the previous year by the Managed Care Plan's fraud investigative unit

<b>MMA Contract Number</b>	<b>Plan ID Number</b>	<b>Cases Open</b>	<b>Cases Closed</b>	<b>Total Number of cases that remain open as of the last day of the previous fiscal year</b>
FP019	0108333	9	5	0

<b>Total of overpayments identified as waste which were recovered</b>	<b>Total of Overpayments identified for recovery which were identified as fraud or abuse</b>	<b>Total amount of overpayments identified as waste that were recovered.</b>	<b>Total amount of overpayments identified as fraud or abuse that was recovered</b>	<b>Overpayment amount not recovered</b>
\$0.00	\$47,623.70	0	\$25,878.00	\$21,745.70