DEPARTMENT:	Compliance
SUBJECT:	Fraud, Waste & Abuse
PRODUCT LINE:	All
POLICY NUMBER:	CP3
ORIGINAL POLICY EFFECTIVE DATE:	01/01/2003
LAST REVISED DATE:	03/14/2024
LAST REVIEWED DATE:	03/14/2024

group health Cooperative of eau claire

KMTSJ, Inc.

SCOPE: To establish a policy in accordance with the Deficit Reduction Act of 2005 ("DRA 2005"), whereby employees, contractors and agents of Group Health Cooperative of Eau Claire (the Cooperative) and KMTSJ, Inc. (KMTSJ) receive information about the Federal False Claims Act and applicable state laws, as well as information regarding Cooperative and KMTSJ policy to detect and prevent fraud, waste, and abuse (FWA) related to federal health care programs and commercially-insured business.

POLICY: It is the policy of the Cooperative and KMTSJ to ensure that employees are educated and trained on fraud, waste and abuse issues to enable them to detect and/or prevent misrepresentations, intentional false claims, improper requests for payment or other questionable transactions. This includes, but is not limited to, annual training and/or specialized training as prompted by Federal and/or State mandates and regulatory changes. A fraud, waste, and abuse policy is one of the fundamental elements in the overall Compliance and Risk Management Program.

PROCEDURE:

Definitions:

- **Fraud**:
  - ✓ A person makes a material statement of fact.
  - ✓ The statement is false and the person making the statement knows that it is false.
  - ✓ The person making the false statement intends to deceive or mislead the person to whom the statement was made with the expectation of receiving something of value.
  - ✓ The person to whom the false statement is made is expected to rely on the statement to his or her detriment.

- **Waste:**
  - ✓ Overutilization of items or services or other practices that result in unnecessary cost.

- **Abuse:**
  - ✓ Any activity that unjustly robs the health care system but does not constitute fraud. In abuse, a provider or consumer may obtain money or health care services to which he/she is not entitled, but there is not the intent to deceive that is necessary for fraud to have occurred. This includes provision of services that are not medically necessary.

In accordance with the DRA 2005 requirements, the Cooperative and KMTSJ will provide new and existing employees, business associates, contractors and agents written information regarding the following:

- The federal False Claims Act (31 U.S.C. Sections 3729-3733);
- Any state laws pertaining to civil or criminal penalties for false claims and statements;
- Whistleblower protections provided under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs, and;

- The role of the Cooperative and KMTSJ Compliance and Risk Management Program, Standards of Conduct, and organizational policies and procedures for detecting and preventing fraud, waste and abuse in federal health care programs.

I. SUMMARY OF SELECTED FEDERAL AND STATE LAWS

The federal False Claims Act, Physician Self-Referral Law, Anti-Kickback Statute, Exclusion Statute, and Civil Monetary Penalties Law, and Wisconsin's Medicaid Fraud Statute are summarized below.

Please note: This list is not exhaustive. These laws are simply selected statutes which are applicable to Federally- and State-funded programs; other FWA laws may apply to commercial business and/or a given scenario.

A. Federal False Claims/FWA Laws

1. False Claims Act [31 U.S.C. § § 3729-3733]

- This law establishes civil liability for offenses related to acts of false or fraudulent claims, records or statements to the government. No specific intent to defraud the government is required.
- It includes actual knowledge, as well as deliberate ignorance or reckless disregard for truth.

2. Physician Self-Referral Law [42 U.S.C. § 1395nn]

- This law prohibits providers from referring patients to receive health services payable to Medicare or Medicaid in which the provider or an immediate family member has a financial relationship.
- It is a strict liability law, which means proof of specific intent to violate law is not required.

3. Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

- This law prohibits knowing and willful offers, payments, solicitations or receipt of any remunerations in cash or kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a federal health care program.
- Remuneration means anything of value and can include gifts, under-market value for the services provided.

4. Exclusion Statute [42 U.S.C. § 1320a-7]

- All health care programs, individuals, and entities convicted of: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or

services under Medicare or Medicaid; patient abuse or neglect; felony convictions for other health-care-related fraud, theft, or other financial misconduct; and felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances are excluded from participation in the Federal health care programs.

- Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.

5. Civil Monetary Penalties Law [42 USC § 1320a-7a]

    - Allows OIG to seek civil monetary penalties for conducting any kind of Fraud, Waste, or Abuse of Federal Health Care Programs

B. State False Claims Laws

1. Medicaid Fraud Statute, s. 49.49 and s. 946.91, Wis. Stats.

    a. This state Medicaid fraud statute prohibits any person from:

        i. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.
        ii. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
        iii. Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial, or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
        iv. Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.
        v. Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

II. ANTI-RETALIATION PROTECTIONS

The Cooperative's and KMTSJ's zero tolerance policy against retaliation protects those who report concerns, in good faith, from adverse action. Anyone who has concerns about retaliation should contact the Cooperative and KMTSJ Compliance Department immediately. The federal False Claims Act and Wisconsin statutes also protect those who report concerns.

A. Individuals who observe activities or behavior that may violate the law in some manner and who report their observations to management or to governmental agencies are provided protection under certain laws.

1. The federal False Claims Act provides protection for those who file lawsuits as described above. The False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken as indicated above is entitled to recover damages. A person is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. An employee can also be awarded litigation costs and reasonable attorneys' fees.

2. Wisconsin statute 146.997, Health Care Worker Protection, also protects health care workers who disclose any of the following to an appropriate individual or agency:

   a. Information that a health care facility or provider has violated any state law or rule or federal law or regulation;
   b. A situation in which the quality of care provided by, or by an employee of, the health care facility or provider violates established standards and poses a potential risk to public health or safety.
   c. A health care facility or provider cannot take disciplinary action against an individual who reports the above in good faith. A health care facility or provider who violates this statute shall be subject to not more than a $1,000 fine for a first violation.

III. ROLE OF FALSE CLAIMS LAWS

The false claims laws discussed above are an important part of preventing and detecting fraud, waste and abuse in federal and state health care programs. They provide government agencies the authority to search for, investigate and prosecute fraudulent activities. Enforcement activities can take place in the criminal, civil and administrative areas providing a variety of remedies to battle these problems.

Anti-retaliation protections encourage reporting and provide more opportunities to prosecute

violations. Employment protections provide the security employees need in order to help the government investigate reported activities.

When there is a credible allegation of fraud (for example, notification from regulatory authorities or internal investigation indicating fraud), the Claims Department and Provider Relations Department will be notified immediately. Payments will immediately be suspended/systems reviewed to ensure no improper payments are made to the party in question until any suspension is lifted.

IV. ROLE OF THE COMPLIANCE AND RISK MANAGEMENT PROGRAM

The Cooperative and KMTSJ are committed to ethical behavior and full compliance with all laws and regulations that apply to our health care business. We have an obligation to act in a way that merits the trust, confidence, and respect of those we serve. We have a Compliance and Risk Management Program to support our commitment to operating with the highest degree of integrity. The Program includes the Cooperative and KMTSJ policies and procedures regarding compliance training and education, auditing and monitoring, and mechanisms for individuals to raise issues and concerns without fear of retaliation. Staff working on Medicare line of business will be required to complete (at hire and annually) the CMS Medicare Part C & D Compliance Training and Fraud, Waste and Abuse Training.

Whether you are an employee, business associate, contractor or agent with the Cooperative or KMTSJ, **you are <u>expected and required</u> to**:

- Act with honesty and integrity in all of your business activities.
- Follow all laws and regulations that apply to your work activities, including the requirements of Medicare, Medicaid and other federal health care programs. The requirements generally include maintaining complete and accurate documentation, and medical records, and submitting only complete and accurate claims for services provided.

Contact any of the following resources, ***immediately,*** if you have knowledge or concern regarding an adverse incident:

- Your department manager/director/supervisor/team leader.
- The Executive Director of Compliance or Director of Compliance. (toll free at (888) 203-7770)
- The Executive Director of Human Resources. (toll free at (888) 203-7770)

Use the Cooperative's and KMTSJ's **<u>anonymous</u>** toll-free hotline phone number, fax, email, or internet reporting tools. The Syntrio Lighthouse reporting mechanisms are absolutely anonymous and your identity will not be disclosed to the Cooperative or KMTSJ unless you request it to be.

***If reporting via Syntrio Lighthouse, please include the company name (Group Health Cooperative of Eau Claire or KMTSJ) along with the details of the issue (who, what, when, how, why) as anonymous reports are very hard to investigate.**

Lighthouse Services, Inc. Anonymous Reporting Contact Information

Telephone:

English speaking USA and Canada: (877) 472-2110 (not available from Mexico)
Spanish speaking North America: (800) 216-1288 (from Mexico user must dial 001-800-216-288)

E-mail: reports@lighthouse-services.com

Website: http://www.lighthouse-services.com/group-health

Fax: (215) 689-3885

In the most extreme circumstances, if a person is unable to report the potential violation within the confines of the company, the issue may be directly reported to the Office of the Inspector General (OIG) by calling:

1-800-447-8477 (1-800-HSS-TIPS)

Such reporting should only be considered when all other reporting attempts have failed to produce action or at minimum, an investigation into the matter.

Processes for Identifying Fraud, Waste and Abuse

The Cooperative has several methods through which FWA is identified, including, but not limited to:

- Pre- and post-payment reviews, including claims pends/auto-denials and recovery of duplicate payments
- Subrogation/recoupment processes
- Coder reviews
- Prior authorization processes
- Review/follow up from concerns brought up by members, providers, or employees
    - FWA reporting information is available in the Member Handbook, Provider Manual, online, and in other formats
- Sending EOBs to members to verify services took place which include contact information for reporting potential FWA matters
- Provider audits/SIU reviews

- Data mining/audits, including, but not limited to:
    - Review of high-level office visit/E&M codes and comparative frequency of billing by diagnosis by provider
    - Requesting notes on corrected claims where the diagnosis has been changed to verify if it is an error or an attempt to bypass coverage exclusions based on diagnosis
    - Obtaining itemized bills for high-dollar surgical claims to ensure all items billed are payable/billable separately from any flat or bundled charge

The Corporate Compliance Committee is tasked with reviewing all FWA-related review processes and establishing regular audits/reports to proactively identify FWA. As part of this review, the Committee will designate responsible employees/departments for completing quarterly reporting, which will be included in the Quarterly Compliance and Risk Management Report.

In-Depth FWA Audits

Through pre-and post-payment reviews and/or regular auditing/monitoring, providers may be targeted for an in-depth review. Circumstances which may justify a targeted audit include, but are not limited to:

- Request by SIU Committee or Claims and Product Quality Manager based on a pattern of billing or FWA-related concerns or referrals;
- Metrics or provision of services that seems outside of the norm for similarly-situated providers (e.g., that could suggest upcoding or overutilization);
- Health Management identification of issues associated with PA requests, including concerns about falsifying or changing medical records

Random audits will be implemented based on a schedule and/or frequency identified by the SIU Committee.

All audits shall be completed within sixty (60) calendar days of a referral from SIU or the Corporate Compliance Committee, unless based on the information requested and/or scope of the audit, this cannot be completed within that timeframe.

DHS and/or OIG Notification of Suspected Fraud and Abuse

It is the policy of the Cooperative and KMTSJ's Compliance and Risk Management Program, under the terms of the Cooperative's contract for services with the Wisconsin Department of Health Services (DHS) to provide Managed Care services for the BadgerCare Plus and Medicaid SSI programs, to report the number of complaints of fraud and abuse made that warrant preliminary investigation. For each complaint that warrants investigation, the Cooperative and/or KMTSJ will supply the following information to the state:

Name
ID number
Source of complaint
Type of provider
Nature of complaint

Approximate dollars involved
Legal and administrative disposition of the case

The Compliance Department will forward preliminary complaint investigation result detail, within 3 business days, to DHS OIG. These complaints will also be compiled internally by the Fraud, Waste, and Abuse Specialist, for tracking and trending purposes. If the preliminary investigation indicates fraud and/or abuse has been committed, the incident is brought before the Corporate Compliance Committee, which is composed of the Cooperative and KMTSJ's Executive Leadership and select key departmental managers, to determine next steps. (e.g., possible legal avenues, contract enforcement, de-credentialing, disciplinary actions, or recovery efforts). The Corporate Compliance Committee shall forward results and details of investigations relating to network providers to the Credentialing Committee for review and processing per their policies and procedures.

The Cooperative and KMTSJ may also be required, or may choose, to report suspected fraud, waste, and abuse to the Wisconsin Medicaid Fraud Control Unit (MFCU) and/or the United States Department of Health and Human Services Office of Inspector General (OIG) for further investigation and review.

Annually, the Cooperative staff will develop and implement a Fraud, Waste, and Abuse Strategic Plan to ensure effective identification, investigation, and reporting of FWA. The updated plan will be submitted to DHS OIG for approval. Once approved, the plan and its components will be implemented by appropriate team members with initiatives and oversight outlined in the plan.

Criteria for External FWA Reporting and Payment Suspension

Reports to the Federal and/or State OIG will be made when a review by the Director of Compliance, SIU, and/or Corporate Compliance Committee or their designees has indicated that fraud, waste and/or abuse has likely been committed by a provider. The Executive Director of Compliance or Director of Compliance will have primary responsibility for completing the report via the "report fraud" buttons located online at: https://www.dhs.wisconsin.gov and/or https://oig.hhs.gov. The report will contain a summary of the issue, actions taken by the Cooperative, and the Cooperative's findings, if any, as well as any supporting documentation. DHS OIG will be notified of all investigations via the Quarterly Program Integrity Report, with specific referrals occurring via separate, direct notification in the event that the Director of Compliance, Executive Leadership, and/or SIU has confirmed fraud or determines that fraud is very likely to be occurring (and additional resources are needed to adequately investigate). In the event of a FWA issue, Provider Relations and QI will be notified to determine whether a contract, claims and/or credentialing suspension and/or termination may be warranted pending review or following completion of a FWA investigation. The Claims and Product Quality Manager may also be notified to suspend payment on any/all claims (*see also*: Provider and Facility Exclusion policy and procedure regarding DHS payment suspension notifications/process). DHS OIG will be notified within twenty-four (24) hours of the suspension of payments using DHSOIGManagedCare@Wisconsin.gov. These suspensions will also be tracked and logged on the terminations/sanctions/suspensions tab of the Quarterly Program Integrity Report.

FWA matters with likelihood of patient/member harm will be reported externally as soon as possible. This determination shall be made by the CMO or designee. All other FWA matters meeting external reporting thresholds will be reported (if not on the Program Integrity Report) within fifteen (15) business days of the

matter being brought to the attention of Executive Leadership or a member of the Corporate Compliance Committee.

The Compliance Department will include, on the Program Integrity Log, the progress of any investigation, including whether (and when) the matter has been reported to DHS/OIG and the reporting method used.

Reference Source, if applicable: Federal Register / Vol. 64, No. 219 / Monday, November 15, 1999 / Notices; Deficit Reduction Act of 2005, Section 6032; s. 49.49 Wis. Stats; CMS 31 U.S.C 3729-3733 31 U.S.C. 3801-3812; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat 119 (2010)

APPROVED: Brandon Thorsness DATE: 03/14/2024

Formal policies and procedures require department manager review, approval and signature. Executive and/or administrative policies and procedures require CEO/General Manager review, approval and signature.

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
08/28/2008	Mark Peterson	
05/20/2010	Mark Peterson	
06/09/2010	Mark Peterson	
03/02/2011	Mark Peterson	
03/08/2011	Mark Peterson	
10/08/2012	Jennifer Rust Anderson, Compliance Officer	
06/19/2013	Jennifer Rust Anderson, Compliance Officer	Updated template/branding; clarification on reporting process and policy wording and adding reference that other FWA laws may apply to commercial business. Added Anti-Kickback, Health Care Fraud and Scheme, Theft or Embezzlement in Connect with Health Care Benefit Program, and False Statements Relating to Health Care Matters.
04/28/2014	Jennifer Rust Anderson, Compliance Officer	Updated typographical error
07/27/2015	Jennifer Rust Anderson, Compliance Officer	Updated Compliance Manager to Compliance Officer

12/14/2015	Jennifer Rust Anderson, Compliance Officer	Clarified language/process regarding suspension of payment for credible allegations of fraud.
08/01/2016	Jennifer Rust Anderson, Compliance Officer	Clarified that annual FWA training for staff involved in Medicare Part D activities will include CMS Medicare Part D Compliance and FWA training
06/21/2018	Jennifer Rust Anderson, Compliance Officer	Added additional detail regarding identification of FWA as well as reporting and tracking mechanisms
06/27/2019	Nick Christensen, Compliance Coordinator	Updated Compliance Officer to Compliance Manager
07/22/2020	Sarah McCracken, Compliance Manager	Updated numbering and grammatical errors.
07/27/2021	Sarah McCracken, Director of Compliance and Government Programs	Updated roles-Director and Manager, instead of simply Compliance Manager
06/13/2022	Sarah McCracken, Ex. Dir. Of Compliance	Updated language to include email and reporting timeframes for FWA suspensions to DHS OIG.
02/07/2023	Terri Hernandez, Director of Compliance	Expanded on details to include when reporting anonymously thru Syntrio. Updated notification to DHS OIG of preliminary complaint investigation result details within 3 business days.
12/19/2023	Sarah McCracken, Executive Director of Compliance	Updated titles and examples of FWA federal laws.
03/14/2024	Brandon Thorsness, Director of Compliance	Minor grammatical edits; adding FWA Specialist