KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Prevention, Detection, and Reporting of Fraud, Waste, or Abuse				POLICY #: 14.04-P	
DEPARTMENT: Compliance Department					
Effective Date: 04/2001	Review/Revised Date: 2/1/2018	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 2/1/18

Chief Operating Officer — Date 1-31-18

Director of Compliance and Regulatory Affairs — Date 1-30-18

POLICY:
Kern Health Systems (KHS) shall establish a system for the prevention, detection, and reporting of fraud, waste, or abuse. Reports will be accepted from KHS employees, members, providers, the public, and regulatory and enforcement agencies. Reports will be reviewed for possible action in accordance with the KHS Anti-Fraud Plan and applicable policies and procedures.

PURPOSE:
To establish written policies for KHS providers and KHS employees[1] that provide[2]:

- Detailed information about the False Claims Act established under sections 3729 through 3733 of Title 31, United States Code
- Administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code
- Any State laws pertaining to civil or criminal penalties for false claims and statements Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)).
- Compliance actions necessary upon receipt of information from the DHCS regarding a credible allegation of fraud pertaining to KHS contracted provider.

PROCEDURES:

1.0 PREVENTION AND DETECTION

The KHS Compliance Department is an internal independent review and investigation department, which is responsible for implementing the Anti-Fraud Plan. The Compliance Department conducts, coordinates, and reports audit and investigation activities for the purpose of preventing and detecting fraud, waste, or abuse in the delivery of health care services to KHS member. The Compliance Department also provides analysis and recommendations regarding the activities reviewed or investigated. Additionally, the Compliance Department initiates investigations and develops preliminary investigation reports for cases of alleged fraud, waste, or abuse. Preliminary investigation findings are forwarded to the appropriate federal or state investigating agency per contract, statute or law.

KHS will report to the DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. KHS will conduct, complete, and report to the DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days from the date that KHS first became aware of or noticed such activity.[3]

Information regarding the prevention and detection of fraud, waste, or abuse is available in the *KHS Anti-Fraud Plan*, which is available upon request.

2.0 DHCS CREDIBLE ALLEGATION OF FRAUD

When DHCS notifies KHS that a credible allegation of fraud has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also part of the KHS' network, KHS will take one or more of the following four actions and submit all supporting documentation to the MCQMD@dhcs.ca.gov inbox: 1) terminate the provider from its network; 2) temporarily suspend the provider from its network pending resolution of the fraud allegation; 3) temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or 4) conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

KHS will notify the DHCS as to which of the above actions will be taken. If KHS elects option 4), the following steps will be taken with all necessary documentation submitted to theMCQMD@dhcs.ca.gov inbox.

1) Immediately implement enhanced monitoring as follows:
    a. Monitor relevant claims, claim lines, and encounter data and complete the initial review with thirty (30) days;
    b. Provide weekly updates to the DHCS until a determination is made as to whether or not an on-site visit is necessary; and
    c. Make an initial determination as to whether an on-site visit is necessary after completing the initial review of relevant claims/encounter data. KHS will consult with the DHCS on the need for an on-site review within ten (10) business days of completing the initial review. KHS will seek DHCS approval if the initial

determ. ation concludes on on-site visit is not v .anted.

2) If KHS's initial determination identifies a potential incident of fraud, waste, or abuse, or otherwise validates DHCS' credible allegation of fraud finding, KHS will:
    a. Commence an audit for the subject provider or subcontractor within ten (10) business days of validating the credible allegation of fraud, waste, or abuse, or within ten (10) days of validating DCHS' credible allegation of fraud. The audit will be conducted earlier if KHS identifies activity that warrants immediate action;
    b. Provide the DHCS with a copy of the final audit report and findings with forty-five (45) days;
    c. Provide the DHCS with a copy of the corrective action plan it has imposed on the Medi-cal provider, which will include specific milestones and timelines for completion;
    d. Provide the DHCS will bi-weekly updates related to the corrective action plan;
    e. Audit the provider or subcontractor again within six months of closing the corrective action plan to confirm amelioration of the findings;
    f. Terminate the provider from KHS' network should there be repeat findings that are significant in nature. KHS will seek approval from the DHCS in situations where the provider is not to be terminated from KHS' network; and
    g. Provide the DHCS with an outline of oversight activity KHS will conduct to ensure there is no further fraud, waste, or abuse.

3.0 TRACKING SUSPENDED PROVIDERS

KHS complies with 42 CFR 438.610, hence the Plan is prohibited from employing, contracting, or maintaining a contract with physicians or other health care providers that are excluded, suspended, or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. KHS will notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.[4]

4.0 REPORTING

Suspicious activities may be reported by phone, in writing, or in person to the Compliance Department. It is recommended, but not required, that written reports be submitted on a *FWA Referral* form (see Attachment A).

Kern Health Systems
Director of Compliance & Regulatory Affairs
9700 Stockdale Highway
Bakersfield, CA 93311
1-800-391-2000

KHS accepts reports from anonymous sources. Reporting parties are encouraged to reveal their identity as it is highly probable that Compliance Department staff and/or others conducting fact-finding/investigative activities will need additional information from the reporter at a later date. Individuals who are unwilling to reveal their identity are encouraged to contact KHS again at a later date for the purpose of answering additional questions.

KHS employees may make anonymous reports by calling the Ethics Line, a contracted employee hotline, which is available exclusively to KHS employees. The hotline number 1-800-500-0333 is open for calls 24 hours a day, 7 days a week.

To the extent reasonably possible, all reports of suspicious activity will be treated confidentially. There is no guarantee of confidentiality on the part of KHS, Compliance Department, the Anti–Fraud Team, or the executive team as KHS may be required to reveal such information to comply with governmental authorities or law enforcement. KHS will take efforts to respect the confidentiality of information by preserving attorney–client privilege whenever possible.

4.1 Investigation of Reports

All reports of suspicious activities are directed to the Director of Compliance & Regulatory Affairs for investigation in accordance with the *KHS Anti-Fraud Plan.*

4.2 Prohibition of Retaliation and Whistleblower Protection

KHS prohibits retaliation against any employee, provider, or member who makes a good faith report of suspicious activity. No employee, provider, or member will be subject to disciplinary action solely because the employee, provider, or member made a report. However, an employee, provider, or member whose report contains an admission of personal wrongdoing cannot be guaranteed protection against disciplinary action. The fact that the individual volunteered the information will be considered as one favorable fact in any disciplinary action.

An employee, provider, or member may be subject to discipline if KHS determines that the employee, provider, or member knowingly fabricated a report in whole or in part.

5.0 THE FALSE CLAIMS ACT

False Claims Act is established under sections 3729 through 3733 of Title 31, United States Code. Under this Act, any person who:

A. Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

B. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

C. Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

D. Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

E. Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

F. Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

G. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the

Governme.., is liable to the United States Governm..nt for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that:

1. The person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;
2. Such person fully cooperated with any Government investigation of such violation; and
3. At the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation;
4. The court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

The False Claims Act includes information on judicial proceedings related to violations of the Act. Providers should review the Act and consult legal counsel to ensure adequate understanding of the requirements and procedures.

ATTACHMENTS:

- Attachment A – FWA Referral Form

REFERENCE:

Revision 2018-01: New FWA reporting form Attachment A. **Revision 2016-01:** Policy revised to comply with APL 15-026. New language added in Section 2.0 DHCS Credible Allegation of Fraud. [1]**Revision 2014-03:** Revised to comply with DHCS Medical Review Audit 2013. Included procedures for tracking suspended Providers. Added language stating results of preliminary investigations of suspected fraud are reported to DHCS within ten (10) working days. **Revision 2012-12:** Revision provided by Director of Compliance & Regulatory Affairs. **Revision 2007-10:** Revised per MMCD All Plan Letter 07007. This letter directs Plans to revise policies in accordance with DRA Section 6032 which created a new Section 1902(a)(68) of the Social Security Act. This new section requires written policies regarding federal and state false claims laws and whistleblower protections. **Formerly:** Reporting of Suspicious Activities to KHS. Name changed during 05/2007 review to reflect the inclusion of items required by MMCD Letter 07007.
This policy applies to KHS providers and employees.

[2] *42 U.S.C. 1396a Sec 1902* (a)(68)(A). See MMCD Letter 07007 for instruction.

[3] DHCS/DMHC 2013 Medical Review Audit (p37 of 37)

[4] DHCS/DMHC 2013 Medical Review Audit (p37 of 37)

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FWA REFERRAL FORM

To submit a request to investigate suspected fraud, waste, or abuse, please complete the KHS FWA Referral Form. Examples of FWA are listed on the FWA Form. These are only examples. The list does not include every situation in which FWA can take place. Use the "Other" category as necessary.

Please note that there is a section on the FWA Referral Form for reporting suspected FWA by a "Member" and/or "Provider". Complete all sections as best as possible. More information is always preferred.

You may remain anonymous, but it should be understood that if you do not provide your name and telephone number, the Compliance Department will not be able to contact you to get additional information, which may help with the investigation.

Submit the completed form and attach supporting documents to KHS' Director of Compliance using one of the following ways:

1. Email: fraudteam@khs-net.com
2. U.S. Mail: Kern Health Systems
   Director of Compliance
   9700 Stockdale Highway
   Bakersfield, CA 93311
3. Fax: (661) 664-5020
4. Phone: 1-800-391-2000

All CORRESPONDENCE SHOULD BE MARKED:
"CONFIDENTIAL: TO BE OPENED BY THE DIRECTOR OF COMPLIANCE ONLY"

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REFERRAL INFORMATION		
Date:		Notice involves suspected fraud, waste, or abuse by a:
Referred by: Name:	Title:	☐ Member
Dept.:	Phone#:	☐ Provider

MEMBER	PROVIDER
Member Name:	Provider Name:
Member ID:	Type of provider:
Address:	Provider ID #:
City: Zip:	Address:
Date of service if applicable:	City: Zip:
	Date of service if applicable:
	Member ID, if applicable: If multiple Members are involved, please attach a list.

MEMBER Suspected Fraud, Waste, or Abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services.
- ☐ Selling, loaning, or giving a Member's identity or documentation of eligibility to obtain covered services.
- ☐ Deliberately providing misinformation to retrieve services.
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the Member for whom the covered service was prescribed or provided.
- ☐ Failing to report other health coverage.
- ☐ Selling and forging prescriptions.
- ☐ Ambulance abuse, overuse of ERs.
- ☐ Illegal doctor shopping & drug-seeking behavior.
- ☐ Other **(please specify in space below)**

PROVIDER Suspected Fraud, Waste, or Abuse:

- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services.
  - ☐ Not actually provided to the Member for which the claim is submitted.
  - ☐ In excess of the quantity that is medically necessary;
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service.
  - ☐ Already included in capitation rate.
  - ☐ Sending Member a bill after Kern Family Health Care has made payment.
- ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a Member.
- ☐ False certification of medical necessity.
- ☐ Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement.
- ☐ Questionable prescribing practices.
- ☐ Other **(please specify in space below)**