Foothills BEHAVIORAL HEALTH Partners

# Detection of Fraud and Abuse

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| **Subject:** Detection of Fraud and Abuse | **Approved:** September 1, 2009 |
| **Subject Area:** Program Integrity | **Revised Effective:** July 1, 2013 |
| **Responsible Department:** Compliance | |
| **Authorized By:** Tom Clay | **Review Schedule:** Annual or as indicated |

**POLICY:**
FBHPartners maintains a proactive corporate compliance program and procedures for the detection of Medicaid fraud and abuse and any other unacceptable business practices that are in conflict with the Corporate Compliance Program and Code of Conduct.

**PURPOSE:**

To achieve a high level of integrity in the operation of the health plan as it pertains to maintaining medical records, reporting of data, use of program funds, and full compliance with all applicable local, state, and federal laws and regulations and contractual requirements.

**DEFINITIONS:**

**Fraud** is the intentional (willful or purposeful) deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Waste and Abuse** include practices that: 1) are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to the Medicaid program, 2) seek reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare, or 3) result in the incorrect, necessary, at the recipient's insistence or request.

**PROCEDURES:**

1. The Corporate Compliance Officer ("CCO") will implement strategies to detect and prevent fraud and abuse, including but not limited to compliance training, auditing and monitoring, and maintaining open lines of communication.

2. **Compliance Training.** The CCO develops and delivers training to employees during new employee orientation and annually. Topics include but are not limited to:

   A. Fraud and abuse laws such as the False Claims Act and Anti-Kickback Statute,

   B. Rights and protections for whistleblowers,

   C. Consequences of non-compliance, and

   D. FBHPartners Corporate Compliance Program.

3. **Auditing and Monitoring.** FBHPartners regularly conducts encounter and claim audits as described the policies and procedures listed below. The CCO may initiate additional auditing and monitoring activities upon identification of a potential issue through routine reviews, referrals from FBHPartners staff, or complaints received through the compliance hotline. Audit results are discussed with the QI Director, CEO, and other staff as needed. The CCO will implement corrective action as necessary and in collaboration with other staff as needed. Other policies:

   A. Monitoring of Encounter Record Accuracy
   B. Maintenance of Medical Records

4. **Compliance Hotline and Open Lines of Communication.** All employees, providers, subcontractors, consultants, and agents of FBHPartners are responsible for reporting potential and/or suspected incidents of Medicaid fraud, waste and abuse, including actual or potential violations of law or regulation.

   A. FBHPartners maintains a confidential and anonymous compliance hotline (303-432-5985) as a vehicle for staff, providers, or members to report instances of known or suspected Medicaid fraud and abuse to the CCO.

   B. FBHPartners QI Department staff maintains procedures for provider reporting of Quality of Care concerns, in which poor quality of care and waste and abuse may be detected (see Policy Quality of Care Concerns).

   C. The FBHPartners Office of Member and Family Affairs (OMFA) monitors grievances and appeals and staff report any concerns regarding possible false claims/encounters, poor standards of care, and fraud or waste and abuse to the FBHPartners Quality Improvement Director and the Corporate Compliance Officer.