HIGHMARK WHOLECARE

Fraud, Waste and Abuse (FWA)

We have a comprehensive policy for handling the prevention, detection and reporting of fraud, waste and abuse ("FWA"). It is our policy to investigate any action by members, employees or practitioners that affects the integrity of our and/or the Medical Assistance and Medicare Programs. Providers are responsible to know the following FWA definitions as applicable to federal healthcare programs:

- **Fraud**: An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a health plan, a subcontractor, a provider, a state employee, or a member among others.
- **Waste**: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse**: Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care in a managed care setting.
- **False Claims Act**: The False Claims Act ("FCA") provides that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approvals (among other activities) is liable to the United States Government for a civil penalty of $5,000 to $10,000 plus three times the amount of damages the Government sustains because of the act of that person. The FCA includes a qui tam provision, where individuals can bring claims on behalf of the Government in exchange for a percentage of any recovery.
- **Compliance Program**: To ensure compliance with FWA requirements of Medicaid contracts, we and providers will have:
    - Written policies, procedures, and standards of conduct readily available for all employees which outlines our commitment to a FWA program;
    - Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors;
    - Mechanisms to report compliance issues or FWA;
    - Enforcement standards through publicized disciplinary guidelines;
    - Provisions for internal monitoring and auditing; and
    - Provisions to promptly take action to detected offenses and develop corrective action initiatives.
- **Payment Integrity**: A multi-faceted team within our organziation that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance to recipient benefits and provider contracts.

- **Clean Claim**: A claim that does not require external investigation or development to obtain information not available on the claim form or on record in the health plan's systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.
- **Non-Clean Claim:** Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Examples of Provider & Member FWA

Provider FWA can include, but is not limited to, the following:

- billing for services not rendered;
- billing separately for services in lieu of an available combination code;
- misrepresentation of the service/supplies rendered including:
    - billing brand named for generic drugs;
    - upcoding to more expensive service than was rendered;
    - billing for more time or units of service than provided;
    - billing incorrect provider or service location;
- altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service;
- billing for services provided by unlicensed or unqualified persons; and
- billing for used items as new.

Member FWA includes, but is not limited to, someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is:

- not reporting income;
- not reporting ownership of resources or property;
- not reporting who lives in the household;
- allowing another person to use his or her ACCESS/MCO card;
- forging or altering prescriptions;
- selling prescriptions/medications; and
- trafficking SNAP benefits or taking advantage of the system in any way.

Provider FWA Training

Providers can find FWA trainings created by our Payment Integrity on the website at www.HighmarkWholecare.com. It is the provider's responsibility to either attend the annual Provider FWA Training or independently review the required materials. Providers will be expected to submit proof of their completion of the training when requested by our organization. Further information and updates concerning the Provider FWA Training can be found on the "Fraud & Abuse" website.

Reporting FWA

If you suspect FWA, it is your responsibility to report the issue to us. You can report FWA in the following ways:

- Call our Fraud Hotline: 1-800-685-5235;
- Email our Special Investigations Unit: SIU@HighmarkWholecare.com;
- Complete a referral form at https://www.HighmarkWholecare.com/fraud-and-abuse; and
- Write to us at: Highmark Wholecare
  Attention: Payment Integrity Department
  Four Gateway Center, Suite 2100
  444 Liberty Avenue
  Pittsburgh, PA 15222

You can choose to remain anonymous when you submit your report. All information received by the SIU will be treated as confidential.

Payment Integrity Recovery Requirements:

We has payment integrity functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits.
- Retrospective claims reviews.
- Provider education.
- FWA investigations and audits.

Our payment integrity functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services ("CMS"), American Medical Association ("AMA"), National Correct Coding Initiative ("NCCI"), National Committee for Quality Assurance ("NCQA"), and state Medicaid regulations. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes: ICD-10-CM, National Drug Codes ("NDC"), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

We will conduct pre-payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. We will recover claims payments that are contrary to national and industry standards. Weh will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews. If any of the payment integrity efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments; We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within sixty (60) days;

- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS I-MEDIC; and

- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from our provider network.

We may pursue overpayments for reasons including, but not limited to, the following:

NCCI Procedure to Procedure (PTP) edits
NCCI Medically Unlikely (MUE) edits
NCCI Add-On Code edits
Retrospective coordination of benefits
Retrospective termed member eligibility
Retrospective rate adjustments
Incorrect fee schedule applied to claim
Provider excluded
Provider license terminated or expired
Provider does not meet the requirements to render services
Different rendering provider
No authorization or invalid authorization
Inaccurate claim information
Duplicate claims
Non-covered service
Outpatient services while member was inpatient
Overlapping services
Patient different than member
Per diem services billed as separate or duplicate charges
Services provided outside of practice standards
Group size exceeds limitations
No services provided including no-shows and cancellations
Missing records
Missing physician orders
Missing medication records
Missing laboratory results
Invalid code or modifier
Invalid code combinations
Diagnosis codes that do not support the diagnosis or procedure
Add-on codes reported without a primary procedure code
Clinical documentation issues

Claims documentation issues
Insufficient documentation
Potential fraudulent activities
Excessive services
Altered/forged records

Payment Integrity Audit

At times, our Payment Integrity will conduct audits regarding FWA. If selected for an audit, the provider will receive a letter from the primary investigator, or delegates that have been contracted by us, requesting medical records or the identification of an overpayment. The letter will include specific instructions on how to respond. Additionally, our partners with multiple vendors to conduct various post-payment audits or reviews. Such audits or reviews could include:

- Retrospective data mining review.
- Subrogation.
- Coordination of Benefit (COB).
- Inpatient chart review.

Medical Record Requests and Standards

We may request copies of medical records from the provider in connection audits regarding alleged FWA. If we request medical records, the provider must provide copies of those records at no cost to we. This includes notifying any third party who may maintain medical records of this stipulation. In addition, the provider must provide access to any medical, financial or administrative records related to the services provided to our members within thirty (30) calendar days of our request or sooner.

We require providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. Additional information regarding basic guidelines for medical records can be found in our Provider Policy and Procedure Manual.

- Providers are responsible for following all requirements under Federal and State regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within sixty (60) days of identification.

- Providers must have member records that include all Medicaid requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. (No clone or copying and pasting of medical records.

Consent to Treatment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by clinician
	Lists the types of services and/or treatments
	Includes the benefits and any potential risks
	Includes alternative services and/or treatments
	Must be easy to read and legible

Release of Information for Payment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Lists the types of services and/or treatments
	Must be easy to read and legible

Privacy Practices	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Must be easy to read and legible

Medical Information	Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
	Allergies and adverse reactions
	Significant illnesses and medical conditions
	Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates
	High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social and emotional risks, etc.)
	Laboratory and other studies ordered
	Continuity of care is documented
	Immunizations and dates
	Must be easy to read and legible

Treatment Plan	Valid for dates of service
	Identifies the patient
	Signed and dated by clinician (witness or author's identification)
	Documents that member or guardian reviewed or participated with the development of the treatment plan
	Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice
	Identifies the diagnosis
	Identifies interventions and goals of treatments
	Documents necessity for treatment
	Reviews are completed timely as applicable
	Must be easy to read and legible

Progress / Clinical Entry Note	Dates of Service
	Identifies the patient
	Signed, dated, and credentialed by author/clinician
	Start and stop times for time based services
	Units of service
	Place of service

	Note is missing narrative/description of services
	Note does not identify the treatment goals and objectives
	Note does not list symptoms and behaviors
	Note does not identify follow-up or next steps in treatment
	Corresponding encounter or timesheets as applicable
	Must be easy to read and legible

Medication List	Medication prescribed
	Signed and dated by clinician
	Lists dosages, dates, and refills
	References the side effect and symptoms
	Must be easy to read and legible