PROVIDER REIMBURSEMENT GUIDANCE			
Fraud, Waste, and Abuse			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
8/03/17	03/01/2022	03/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

The Fraud, Waste and Abuse payment policy has been implemented to ensure that Commonwealth Care Alliance (CCA) fulfills its responsibility to follow The Centers for Medicare & Medicaid Services (CMS) and The Executive Office of Health and Human Services (EOHHS) rules, laws, regulations, contract provisions, policies, and procedures. CCA shall not be liable for charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation, and reserves the right to recover any overpayments resulting from improper billing practices.

CCA monitors provider payment integrity to confirm that all claim submissions accurately represent the services provided. Under the Fraud, Waste, and Abuse Program, CCA utilizes a variety of methods to detect, prevent, investigate, and correct fraud, waste, abuse, and other instances on non-compliance or improper billing. CCA periodically conducts claims review audits to ensure quality claims adjudication performance. The claims data and/or medical records are reviewed to verify services, level of care, appropriateness of billing, and proper documentation. All services provided should be billed in accordance with CMS and EOHHS applicable standards.

CCA may initiate a Provider payment integrity investigation upon identification of indications of inappropriate or illegal activity, including but not limited to potential fraud, waste or abuse, improper billing or payments, contract violations, adverse administrative action imposed by State or Federal agencies, inclusion on State or Federal exclusion or preclusion lists, and substantial quality of care concerns.

PROVIDER CODING COMPLIANCE:

CCA encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10, PCS). CCA, CMS and/or EOHHS may audit a provider at any point for over-coding and/or similar billing practices related to Fraud, Waste and Abuse. Providers are encouraged to contact CCA Provider Relations at (800) 341-8478 to request education about coding and/or documentation compliance.

INVESTIGATION PROCESS:

The CCA FWA department may suspend payments to any provider when there is reliable information that the provider has improperly billed CCA. Payments will be suspended as CCA deems appropriate and a suspension notice will be sent to the provider by the FWA department.

During the investigation review process, providers will be required to comply with all reasonable requests made by CCA for supporting information and documentation. For any provider under review, CCA shall have the right to evaluate through inspection, evaluation, review or request, or other means, whether announced or unannounced, any record pertinent to the review. These records may include, but are not limited to, medical records, billing records, financial records, downstream contracts, policies, and procedures, and/or any records related to services rendered, quality, appropriateness, and timeliness of services. Such evaluation, inspection, review, or request, when performed or requested, shall be executed with the immediate cooperation of the Provider. Upon request, the Provider shall assist in such reviews and provide complete copies of medical records. Failure to cooperate with any audit or investigation will result in the denial or recoupment of claims in question, and remedial action up to and including termination of contracts.

REPORTING PROTOCOL:

Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone including members, providers, sub-contractors, and CCA employees. Anyone that knows of or suspects fraud and abuse activity should report such activity in one of the following ways:

- Call the CCA Compliance Hotline at 866-457-4953 (can be reported anonymously)
- Submit a Compliance Incident Report
- Send mail to:

  Commonwealth Care Alliance
  FWA Program and SIU
  30 Winter Street, 11th Floor
  Boston, MA 02108

CCA will protect the interests of its members, employers, and providers against those who knowingly and willingly commit fraud or other unlawful acts and will identify, resolve, and recover funds. Reporting and legal action will take place when necessary if suspected fraud, waste, and/or abuse has occurred.

- CCA will not retaliate against anyone who makes a good faith report of potential fraud or other unlawful acts.
- Various state and federal laws protect those who make a good faith report of potential fraud.

It is important for providers to understand the legal and regulatory requirements concerning health care fraud. The following are examples of specific laws in place:

- <u>False Claims Act</u>
  - The False Claims Act is a federal statute that covers fraud involving any Federally funded contract or program, including, but not limited to the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.
  - The term “knowing” is defined to mean that a person with respect to information:
    - Has actual knowledge of falsity of information in the claim
    - Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim.
  - Health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as the following:
    - Knowingly making false statements,
    - Falsifying records,
    - Double billing for items or services,
    - Submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.
- <u>Anti-Kickback Statute</u>
  - This law imparts criminal and civil penalties for persons or entities that knowingly and intentionally offer, pay, solicit, or receive remuneration to persuade or reward business payable or reimbursable under the Medicare or other Federal health care programs.
- <u>Stark Law</u>
  - The Stark Law provides penalties for individuals or entities that do not adhere to the regulations regarding financial arrangements between referring physicians (or a member of the physician’s immediate family) and entities that provide certain designated health services payable by Medicare or Medicaid. It does not require any showing of intent on the part of the wrongdoer.

The services a provider offers to CCA's members are subject to both federal and state laws.

- Contract requirements have also been designed to prevent FWA in government programs (such as Medicare and Medicaid) and private insurance.
- A provider's submission of a claim for payment also represents the provider's interpretation that the claim is not submitted as a form of, or part of, fraud and abuse as listed below, and is submitted in compliance with all federal and state laws and regulations.

Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents.

- Any amount billed by a provider in violation of this policy and paid by CCA constitutes an overpayment by the Plan that is subject to recovery.
- A provider may not bill members for any amounts due resulting from a violation of this policy.

Providers must understand, recognize, and prevent fraud and abuse. The following is a list of examples of potential fraud and abuse:

1. Billing for services not rendered
2. Billing for services that are more complex than what was really provided (upcoding)
3. Performing (and billing for) services that are not medically necessary to obtain an insurance payment
4. Changing the rendering physician and/or services to get the claim paid after the claim was denied
5. Falsifying a diagnosis to support testing or services not otherwise necessary or covered
6. Soliciting, offering, or receiving referral fees or waiving member's deductibles, coinsurance, or copayments (i.e., kickbacks)
7. Referring patients in exchange for other services
8. Prescribing a prescription that has no legitimate or medical purpose
9. Practicing "defensive medicine" by ordering medical tests or procedures as a safeguard against possible malpractice liability, not to ensure a patient's health
10. Charging excessively for services, procedures, or supplies
11. Submitting claims for services not medically necessary or services not medically necessary to the extent provided (for example: a panel of tests is ordered when based upon the patient's diagnosis only a few of the tests, if any at all, within the panel were actually necessary)
12. Unbundling
13. Billing multiple times for the same service (duplicate billing)

Consistent with CMS standards, medical records must contain information to justify treatment, admission, or continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to patient eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to CCA policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

CMS Website
EOHHS Website
ICD-10-CM Official Guidelines for Coding and Reporting FY 2017
CCA Provider Portal

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. Drafted July 2017
2. Effective 8/03/2017
3. Revised October 2021; added MAPD