

**Objective:**

- I. To ensure Tuality Health Alliance (THA) has a mechanism in place that will enable THA to prevent and detect fraud and abuse activities relating to THA members and providers.
- II. To identify, evaluate and reduce the potential risk management concerns associated with care and services by anticipating problems and taking preventive measures.
- III. To educate THA providers, employees and contractors of their accountability in monitoring and identifying potential fraud and abuse.

**Definitions:**

**Abuse:** Abuse includes Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to Medicare, Medicaid, THA or an enrollee, or in reimbursement for services that are not necessary or that fail to meet professionally recognized standards for health care. Abuse also includes Enrollee practices that result in unnecessary costs.

**Exclusion:** Exclusion means that THA will not reimburse a specific provider who has defrauded or abused THA for items or services that the provider furnished.

**Fraud:** An intentional deception or misrepresentation, whether by act or omission, made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable state or federal law.

**Incident:** A situation of possible fraud, abuse, or waste.

**Suspension:** Suspension means that THA will not reimburse a specified provider who has been convicted of a program related offense in a federal, state or local court for items or services that the provider furnished.

**Waste:** An incident or practice that is inconsistent with accepted and sound medical business or fiscal practices that directly results in unnecessary cost to Medicaid, Medicare, THA or an enrollee.

**Policy:**

- I. THA will prohibit any acts of intentional deceptions or misrepresentations made by a person that “knowingly” acted with the knowledge that the deception(s) could result in some unauthorized benefit to him/her or some other person. This includes the prohibition of any act that constitutes Fraud under applicable federal or state law. THA will not “knowingly” contract with provider practices that are inconsistent with sound fiscal business or medical practices that result in an unnecessary cost to the Division of Medical Assistance Programs (DMAP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. If THA is already contracted with a provider practice that intentionally abuses DMAP it will report the fraudulent activities as outlined in this policy.
- II. THA contracts with various providers to provide care to members. These contracts will include “fraud and abuse” language specific to financial relationships with its subcontractors.
- III. The Chief Compliance Officer for THA is the THC Corporate Chief Compliance Officer. This position is appointed by the CEO and is responsible for ensuring the operation and monitoring of the fraud and abuse program. The Chief Compliance Officer reports directly to the THA Board of Directors. This position is also responsible for ensuring the integrity of the claims payment and encounter reporting process as well as retaining overall responsibility for the financial relationships with providers.
- IV. THA will educate staff and subcontractors regularly through the THC Corporate Compliance Education Program as well as the THA Newsletter, Provider meetings, Office manager meetings and CME presentations.
- V. THA maintains confidentiality and anonymity of any receipt of information or complaint. An anonymous reporting mechanism allows employees and vendors to immediately and without fear of retaliation report suspected violations.
- VI. The Chief Compliance Officer maintains a record on every compliance complaint received, which, at a minimum, shows for each record:
  - A. The date received;

- B. The manner in which the report was received, e.g., anonymous hotline;
  - C. A brief statement of the facts as alleged;
  - D. Notes detailing the Chief Compliance Officer's investigation;
  - E. Action taken;
  - F. Date resolved, and
  - G. Within 30 days of receipt that it is either completed and closed or ongoing investigatory notes exist
- VII. THA will evaluate any allegations of improper/illegal activities through the Quality Management (QMC) Committee.
- A. When a possible adverse action is identified by a provider, he/she will have the opportunity to respond with explanation and defense before the QMC Committee according to THA policy # IX-1 Peer Review and # X-6 Practitioner Appeal Rights.
  - B. Any adverse action identified will be reported to the appropriate Federal or State health care agency.
- VIII. THA utilizes various risk evaluation techniques to monitor compliance and assist in the reduction of fraud and abuse:
- A. McKesson InterQual Guidelines for monitoring over/under utilization
  - B. Utilization management reports – monthly or quarterly
  - C. Queries, i.e. data queries to monitor usage
  - D. Physician queries through the Office of Inspector General
- IX. THA does not contract or reimburse providers for covered services who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, SCHIP or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws. Providers may utilize THA's Peer Review or appeals process.
- A. THA's Credentialing and Re-Credentialing process utilizes the National Practitioner Data Bank (NPDB) to identify sanctioned providers.
  - B. THA reviews the Office of Inspector General's Sanction list, the Noridian Excluded Provider listing and the Oregon Medical Board prior to initial credentialing, prior to recredentialing and the monthly sanctions report for sanctioned providers.

- X. As required by the contract with The Department of Human Services in the State of Oregon, THA will maintain a system of detecting and responding to fraud and abuse allegations as such activities relate to the plan's administration of medical benefits to DMAP Clients. This will include, but is not limited to the implementation of operational policies and controls, reporting, education efforts and auditing.

A. Standards of Conduct

THA will distribute to its contractors, employees and subcontractors the THA written Standards of Conduct and written policies and procedures that delineate THA's commitment to compliance, and will maintain contractual requirements that all State/Federal laws and THA policies and procedures must be followed. The Standards of Conduct will include:

1. THA's commitment to compliance
2. Address specific areas of potential fraud such as claims submission process and financial relationships with its subcontractors
3. Detailed information about the False Claims Act established under Sections 3729 through 3733 of title 31 USC
4. Administrative remedies for false claims and statements established under chapter 38 of title 31, USC
5. Any Oregon laws pertaining to civil or criminal penalties for false claims and statements
6. Whistleblower protections under such laws with respect to the role of these laws in preventing and detecting fraud, waste and abuse in Federal health care programs as defined in 42 USC 1320a-7b.
7. Oregon laws include the following:
  - a. ORS 411.670 to 411.690- submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery
  - b. ORS 646.505 to 646.656- unlawful trade practices
  - c. ORS chapter 162- crimes involving fraud or deception including but not limited ORS 165.080 falsification of business records
  - d. ORS 165.690 to 165.698- false claims for health care payments
  - e. ORS 166.715 to 166.735- racketeering; civil or criminal
  - f. ORS 659A.200 to 659A.224 and ORS 659A.230 to 659A.233 whistle blowing
  - g. OAR 410-120-1395 to 410-120-1510 program integrity, sanctions, fraud and abuse

- h. Common law claims founded in fraud, including fraud, money paid by mistake and money paid by false pretenses.

**B. Designation of Chief Compliance Officer and Governing Bodies**

The THA Chief Compliance Officer is charged with the responsibility to ensure the monitoring of Plan and Provider activity through claims audits, review of grievance and appeals reporting, operational processes and ways of communication, means of reporting fraudulent activities, and in acting as a consultant for maintaining plan compliance with current State and Federal rules and regulation. In the event the Chief Compliance Officer delegates these activities, the delegate will report results directly to the Chief Compliance Officer who will report directly to the THA Board of Directors.

**C. Education and Training**

- 1. The Plan Director, as delegated by the Chief Compliance Officer, shall develop and establish an on-going training and education program for providers and employees. This program shall complement the employee's annual Corporate Compliance Training and will include additional information for:
  - a. Fraud & Abuse Reporting
  - b. Detection and Compliance Responsibilities
  - c. HIPAA
  - d. Changes or updates to relevant THA policies
  - e. Personal rights and responsibilities under the False Claims Act including incentives for doing so under "Qui Tam" (whistleblower) laws for THA Staff.
  - f. Other topics as identified or required
- 2. Records of staff attendance at these training forums will be retained in the employee's personnel file. Records for provider and contractor training will be recorded in a centralized location and will include attendance records for centralized events.

**D. Procedure/System for Collecting Enrollee Complaints**

All member and provider initiated grievances are tracked and monitored in the THA Complaint Database. The Medical Services Manager is responsible for monitoring all grievances to ensure prompt resolution or to identify in the event there is need for further investigation. Reports will be compiled reviewed by the THA Medical Services Manager and when necessary the Chief Compliance Officer. Any areas that indicate a high volume of incidents will be further

investigated. In the event that a grievance cannot be completely resolved, a determination will be made by the THC Chief Executive Officer, the THA Chief Operating Officer and the Chief Compliance Officer. THA will submit grievance reports on a quarterly basis to the Division of Medical Assistance Program (DMAP). The THA QMC review complaints on a quarterly and annual basis to detect trends to determine quality performance initiatives. The THA QMC reviews denials and appeals monthly.

**E. Sanctioning and/or Corrective Action**

1. Any Provider who is currently suspended or terminated by DMAP or who is suspended, disbarred, or otherwise terminated or excluded by CMS may not provide services to THA Members.
2. Providers, suppliers or other subcontractors who are suspended or terminated by DMAP or CMS must report this action to THA within 2 business days of the decision.
3. Providers or entities who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act and/or related laws (or entered a plea of no lo contendere):
  - a. Shall not have THA OHP members referred to them and THA will not accept any billing for services provided to members by these providers
  - b. May not be a director, officer, employee, consulting or other agreement with a person described in section X. E. 3. above.
4. THA will assist Members in obtaining a new provider in the event that their provider is terminated, in order to ensure continued access to medical care. THA has a process in place through its Credentialing Office to detect provider sanctions, suspensions, and exclusions via the DHHS and OIG website.
5. Confirmed cases of fraud and abuse carry with them a variety of penalties. Sanctions can include, but are not limited to, the following:
  - a. Suspension: Provider claims can be processed but not paid.
  - b. Exclusion:
    - i. Based on State law, THA or DMAP can exclude a provider from participation for financial misconduct, including not having records to support claims.
    - ii. Mandatory Exclusion by Federal Government: The Federal Government, through OIG, can impose

various administrative sanctions, including civil money penalties and program exclusion.

- iii. Termination of Provider Contract
- iv. Termination of Employment:

**F. Preventing Submission of False Claims**

1. THA's claims processing system uses software to detect inconsistent billing practices, called clinical edits. This allows THA to deny any claim submitted that is not billed correctly and/or not pay on claims filed with inconsistent billing. The system also allows THA to deny and detect false claims submitted on behalf of members that do not exist and/ or are not eligible for benefits. A portion of THA's providers are audited on an annual basis to detect improper coding based on medical chart review.
2. Every 45 days THA completes a random sample of DMAP members whom received services. This sample is based on paid claims from a randomly selected month and a randomly selected DOB. A list of members is generated and an Explanation of Benefit (EOB) Questionnaire is created and distributed to member. The EOB Questionnaire provides: Date of Service; Provider and Type of Service. The member is asked to answer the following questions:

Did you pay for anything?  
Did you receive all of the services below?  
If you did pay, did you get your money back?  
What is your telephone number?

The members are asked to complete the questionnaire and return to Tuality Health Alliance in a postage paid envelope.

All distribution lists are maintained by Customer Services on M:\Share\THA\TPA\EOB Mailings by check run date\YYYY\_OHP.

3. If a member contacts THA regarding an EOB; Customer Service reviews the details of the charge to verify if the member truly received the billed services. If the member still disagrees with the billed services the billing office is contacted to verify the billed information and/or member payment
4. If there continues to be a discrepancy between the member and

the Provider's office, chart notes will be requested and forwarded to Case Management for further review and further action.

5. THA will provide, upon request from DHS, verification that DMAP members were contacted to confirm that billed services were provided.
  - a. Providing notice, within 45 days of payment of a claim, to all or a sample group of the DMAP Members who received services. The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.
  - b. Notice must specify
    - i. The service furnished
    - ii. Name of the Provider furnishing the service
    - iii. The date on which the service was furnished
    - iv. The amount of the payment made by the DMAP Member, if any, for the service.

**G. Internal Monitoring and Auditing**

1. The THA Medical Management Department will conduct at a minimum quarterly audits of the following areas:
  - a. Utilization review of services provided
  - b. Review of Prior Authorization Determinations- this includes all actions taken to determine the medical appropriateness of services or items. See related THA policy V-3 Member Referral/Pre Authorizations
  - c. Service Verification
  - d. Quality Review-this includes onsite reviews to provider offices to review medical records against submitted claims
  - e. Review of Grievance and Appeals report for indication of potential fraud or abuse
  - f. Provider Credentialing and contracting
  - g. Review of QMC Meeting minutes, reports, and special projects.
  - h. Claims reviews-annually on selected providers for quality improvement activities or as directed by THA's QMC.
2. THA utilizes risk evaluation techniques to monitor compliance in identified problem areas. If an area fails to pass an audit with 95% accuracy, the reason for failure will be documented and evaluated, and staff will be educated. If corrective action is implemented, the Chief Compliance Officer or their delegate will follow up with further

auditing or investigation, as needed and enforce corrective action and/or discipline where it is necessary. The process utilizes audit tools and sample sizes based on CMS, DMAP and/or NCQA guidelines for auditing claims processing, appeals and grievance system, and plan Actions.

3. Audit results are presented to THA's Plan Director, QMC and to the Board of Directors when necessary.

H. Referral

THA Chief Compliance Officer or their delegate will investigate allegations of fraud and abuse. THA will promptly report *verified* cases of fraud and abuse, including fraud and abuse conducted by employees and subcontractors of THA, to the Medicaid Fraud Control Unit (MFCU). The Risk Management Coordinator will also report any cases of *suspected* fraud and abuse to the MFCU *prior to* verification, at their discretion.

Reporting Provider Fraud  
Medicaid Fraud Unit  
1515 SW 5<sup>th</sup> Ave Suite 410  
Portland, Or 97201  
Phone number is 503-229-5725  
Fax number is 503-229-5459

DHS Provider Audit Unit  
2850 Broadway St. NE  
Salem, OR 97303  
Phone number is 503-378-3500  
Fax number is 503-378-3437

Reporting Member Fraud  
DHS Fraud Investigation  
P.O. Box 14150  
Salem, OR 97309-5027  
1-888-372-8301  
Fax 503-373-1525  
ATTN: HOTLINE

1. Examples of fraud and abuse THA monitors for within THA's network:

- a. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the clinical record. This would include any suspected case where it appears that the Provider knowingly or intentionally did not deliver the service or goods billed.
- b. Providers who consistently demonstrate a pattern of intentionally reporting overstated or up coded levels of services. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher-level procedure code than is documented in the clinical records.
- c. Any suspected case where the Provider intentionally or recklessly billed THA more than the usual charge to non-Medicaid recipients or other insurance programs.
- d. Any suspected case whether the Provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating and /or collecting payments not due. This would include any deliberate misrepresentation or omission of fact that is material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identify of the patient or provider.
- e. Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to THA members.
- f. PCPs who intentionally misrepresent medical information to justify referrals to other networks or out of network providers when they are obligated to provide the care themselves.
- g. Providers who intentionally fail to render medically appropriate covered services that they are obligated to provide to THA members under their contracts with THA and OHP regulations

- h. Providers who knowingly charge THA members for services that are covered services or intentionally balance-bill a THA member the difference between the total fee for service charge and THA's payment to the Provider.
    - i. Any suspected case where the Provider intentionally submitted a claim for payment that already has been paid by THA or upon which payment has been made by another source without the amount paid by the other source clearly entered on the claim form, and receipt of payment is known to the provider.
    - j. Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.
  - 2. Fraud and abuse in the administration of the THA OHP program may include evidence of corruption in the enrollment and disenrollment process including efforts of THA to skew the risk of unhealthy patients toward or away from THA.
  - 3. Examples of fraud and abuse by a member may include:
    - a. A member permits use of his/her medical ID card by others.
    - b. A member is known to alter a prescription.
    - c. A member commits theft or other criminal acts in any Provider or PHP's premises.
  - 4. Examples of patient abuse and neglect may include:
    - a. Any provider who hits, slaps, kicks, or otherwise physically abuses any patient.
    - b. Providers who sexually abuse any patient.
    - c. Any provider who intentionally fails to render medically appropriate care as defined by the OHP contract, OARs and standard of care within the community in which the provider practices. If the provider fails to render medically appropriate care in the compliance with the THA Member's decision to exercise his or her right to refuse medically appropriate care or because the THA member exercises his rights under Oregon's Death with Dignity Act or Advance Directives, such failure to treat the member shall not be considered abuse or neglect.
    - d. Providers who deliberately neglect their obligation to provide care of vulnerable persons who are THA

members (e.g. developmentally disabled, children, elderly).

- I. Effective Lines of Communication and Protection of Anonymity  
The Chief Compliance Officer or their delegate will educate employees and Providers and/or Contractors in how to refer or report allegations of fraud and abuse to the THA, through the anonymous hotline at Tuality Healthcare, to the State of Oregon DHS and to the Federal HHS. The Chief Compliance Officer can be reached via email, phone or in person during business hours. The Chief Compliance Officer maintains an “open door” policy, and will act to ensure that confidentiality is maintained. Employees and Providers are given the option to maintain their anonymity by reporting an allegation or complaint via the toll-free number: 1-866-297-0489.

Written reports of fraud and/or abuse may be sent to:

Attn: THA Chief Compliance Officer  
Tuality Health Alliance  
P.O. Box 925  
Hillsboro, Or 97123

For questions or concerns regarding Fraud and Abuse, employees and providers are instructed to contact the DHS Fraud Hotline at (888) 372-8301.

- J. Protection from Retaliation  
Neither THA as an entity nor any THA employee will intimidate, threaten, coerce, discriminate against, or take any other form of retaliatory action against any individual for exercising any right established under THA or THC policy, or for participating in any process established under THA policy, including the filing of a complaint with THA or with DHS, testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing relating to THA policy and procedures; or opposing any unlawful act or practice, provided that the individual or other person (including an THA employee) has a good faith belief that the act or practice being opposed is unlawful; and The manner of such opposition is reasonable and does not involve a use or disclosure of an individual’s protected information in violation of THA policy.

- K. The THA Fraud, Waste and Abuse Program is monitored and reviewed by the QMC on an annual basis. The Chief Compliance Officer is responsible for presenting an annual analysis of program efforts and outcomes to the Plan Director, QMC and to the Board of Directors.
  
- XI. THA will allow and facilitate the Medically Fragile Children's Unit or the Department of Human Services to inspect, evaluate, or audit any records, documents, files, accounts and/or facilities maintained and contracted with THA as required to investigate an incident of fraud and abuse.
  
- XII. Tuality Healthcare Required Education
  - A. Tuality Healthcare (THC) employees will receive education on the organization's compliance program at initial orientation and annually thereafter. All employees are charged with ensuring the organization's adherence to each of the standards established in the Values Statement for the compliance program of Tuality Healthcare. Employees must express concerns regarding any aspect of Tuality Healthcare's business which they feel conflicts with the values statement.
  
  - B. Each Tuality Healthcare employee is responsible for assisting in compliance activities. No person will be subject to any retaliation or disciplinary action from Tuality Healthcare for good faith reporting under this program, even if allegations made in good faith are found to be groundless. Failure to report known or suspected violations may be grounds for disciplinary action including discharge. Each employee must accept the principle that an ethical organization depends on ethical employees obligated to provide full services for salary paid and that failure to do so is a violation of the compliance program.
  
  - C. Each Tuality Healthcare employee is charged with assisting the institution in its efforts to adhere to the highest ethical and professional standards and to correct immediately any deviation from legal or regulatory standards. Specifically, all Tuality Healthcare employees will:
    - 1. comply with all policies and procedures, such as corporate, facility and departmental, etc.;

2. comply with all applicable state and federal rules and regulations;
  3. conduct themselves with the highest standards of honesty and integrity;
  4. treat all patients, customers, business associates and the public with respect, dignity, and understanding;
  5. utilize Tuality Healthcare's formal reporting mechanism and/or anonymous reporting system to report any observed or suspected deviations from the standards established in the organization's values statement, and
  6. receive initial and annual education on compliance duties and on mechanisms in place to ensure compliance
- D. All THC policies are posted on the intranet and are the responsibility of every THA employee to review policies and educational requirements in Healthstream annually. These requirements are publicized at minimum on orientation, prior to annual employee performance development session and as necessary.

Attachment A      False Claims Act Sections 3729-3733 of title 31 USC

Related policies:    THA policy VII-6 Member Confidentiality  
                          THA policy IX-1 Peer Review  
                          THA policy II-1 Claims Processing  
                          THA HIPAA policies Section II  
                          THA Credentialing policies Section X  
                          42 USC 1320a-7b.  
                          42 CFR 455.20  
                          42 CFR 433.116(c)(f)  
                          ORS 411.670 to 411.690  
                          ORS chapter 162  
                          ORS 165.690-165.698

ORS 166.715-166.735  
ORS 659A.200659A.224 and ORS 659A.230-659A.233  
OAR 410-120-0000  
OAR 410-120-1395 to 410-120-1510  
OAR 410-141-0080 (2)(a)  
THC O-092 Compliance Program  
THA DMAP 2011 Contract Exhibit J Prevention and  
Detection of Fraud and Abuse  
THC Corporate Compliance Program O-93  
False Claims Act Sections 3729-3733 of title 31 USC which  
is found at :  
<http://uscode.house.gov/download/pls/31C37.txt>

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**THA Plan Director**

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**THA Medical Director**