Hometown Health Plan		Current Version Effective Date:	02/28/13
		Next Review Date:	02/28/14
Title:	Audit Procedures to Review Claims for Fraud, Waste, Abuse Detection and Prevention Program	Creation Date:	02/26/07
Category:	Operations: Fraud, Waste, Abuse, Detection, Prevention and Correction Program	Revision History:	
Number:	Hometown.COP.500.001	10/25/12	__/__/__
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Scope:

1) Unless otherwise limited, this Policy and Procedure apply to:

   A) All fully insured products administrated by Hometown Health (HTH), and

   B) All Entities who provide billable services to members on behalf of HTH.

Purpose:

To establish the methods of identifying, responding to, and investigating reported or identified potential policy violations of the governing federal and state regulations and Hometown Health's Compliance Program and other policies.

Policy:

It is Hometown Health policy to implement policies and procedures which are designed to protect the Medicare Advantage Prescription Drug Plan, and Commercial insurance products from fraud, waste, and abuse by detection, prevention and correction activities.

Definitions:

Fraud – means an intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself or to some other person. It includes any act that constitutes fraud under applicable Federal or State Law.

Waste – means the over-utilization of services not caused by criminally negligent actions; waste involves the misuse of resources.

Abuse – means the provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in the unnecessary cost to the Plan, or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care.

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Overpayment – means claims payment for provider, contractor, or other entity - has received in excess of amounts payable under the Plan allowances and Medicare statues and regulations for services rendered to the member.

Entities - means all physicians, allied health providers, vendors, network pharmacies.

Procedures:

1) Overview

A) Hometown Health conducts administrative reviews of paid claims for services rendered to our members.

B) The objectives and components relating to the Provider claim reviews are outlined below:

1) To ensure that providers have retained appropriate documentation meeting all Hometown Health program requirements, all applicable federal and state requirements, in support of each claim in accordance with the Hometown Health Provider Agreement;

2) To ensure that the services billed were received by the member; and

3) To detect billing irregularities.

C) Hometown Health uses software to detect, track, analyze, and report instances of health care fraud or misrepresentation. The software compares data from different sources (i.e. facility, pharmacy, and provider) which applies rules- based analysis to test anomalous payment patterns.

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D) Hometown Health also employs several lead activities that may demonstrate potential suspect activities such as:

1) Complaint tracking

2) Leads from other internal departments and Hometown Health's PBM

3) Fraud and Abuse Hotline

4) Other notifications; letters, Office of Inspector General Work Plan (OIG)

E) Legal counsel shall be consulted at the beginning of any investigation.

2) Evaluation of Claims Data – Automated

A) Claims data will be surveyed and evaluated - including provider/facility history, specialty profiles, common fraud schemes and claims patterns that differ from past history or peer norms for a given condition or specialty.

3) Process for automated review

A) Each quarter's data will be uploaded by Information Resources (IR) into the software system. Decision Support will assist in providing an analysis of the current data. The compliance department will provide investigational support to the issues identified.

B) Upon suspicion of potential fraud and/or abuse, the Medical Director, Vice President, and Corporate Compliance Officer (Senior Leaders) will be notified.

C) Audits will be conducted to include a review of paid and/or denied claims, medical records, and possible interviews with providers and members. The Compliance department will perform data collection functions and coordinate other activities as required.

D) Physician Peer Review will be conducted by an independent third- party (Board Certified) in a like medical specialty, as appropriate. HTH will provide copies of the medical records to the reviewer, in addition to providing specific review parameters and questions based on clinical practice guidelines for analysis of medical documentation and claim detail.

E) Senior Leaders, upon review of the written Peer Review report, will conduct an on-site meeting with the provider to share the audit results and solicit feedback. HTH will require a written response from the Provider within 10 business days of the meeting.

F) Based on the Peer Review findings, HTH may initiate corrective or disciplinary action against a provider or contractor after consultation with legal counsel, so that the action complies with, and will not be subject to challenge under terms of employment, contractual provisions, or other statute or regulation governing the relationship between HTH and the individual against whom the action has been recommended.

G) Senior Leaders, in consultation with legal counsel will make decisions on whether / what actions should be taken as a result of the identified issue(s). Typically, actions may include but are not limited to the following:

1) Corrective Action Plan (CAP)

2) Physician Education

3) Monitoring and Auditing

4) Suspension of claims payments pending documentation review

5) Recovering inaccurate payments

6) Contract Revisions / Modifications

7) Termination from Network

H) If the incident meets the definition of a reportable offense, Senior Leaders, with consultation of Legal and Corporate Compliance *may/shall report it up to the appropriate law enforcement or regulatory agency (State Medical Board, Nevada Attorney General, and Office of Inspector General (OIG), using whatever form or document required by that entity.

I) Additionally, routine randomized audits will be undertaken annually to ensure providers, pharmacies, and all subcontractors are conforming to generally acceptable health insurance billing and payment standards. These routine audits will encompass both desk and on-site audits as appropriate.

4) Repayment of Identified Overpayments

A) Upon identification of trends and patterns, HTH may require repayment. Repayment may occur in the following manner:

1) For all Medicare Advantage Plans, provider overpayments, repayment is required.

2) HTH may request the refund amount to be paid by check based on the overpayment discovered from the audited claims;

3) Overpayments may be deducted from amounts otherwise due to the provider from future payments.

B) All restitutions will be credited to the appropriate lines of business so as to maintain accurate records with respect to Federal, state, or self-funded employer monies.

5) Reviewing Program Benefits and Contracts

A) As part of the process HTH will review:

1) Benefit coverage for refinement opportunities; and

2) Provider contract set up for refinement opportunities;

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6) Hometown Health will report incidents that meet the definition of a reportable event according to appropriate state and federal guidelines.

References:

Medicare Prescription Drug Benefit program regulations, 42 Code of Federal Regulations Part 423;

Medicare Advantage program regulations, 42 Code of Federal Regulations Parts 422;

Medicare Prescription Drug Benefit Manual, Ch. 9 (Compliance Program Guidelines); and

Medicare Managed Care Manual, Ch. 21 (Compliance Program Guidelines)

Nevada False Claims Act [Nev.Rev.Stat. §357.040]

Federal False Claims Act [42 U.S.C. § 1396a(a)]

Hometown. FWA.004 Policy – Specific Process for Monitoring Delegated Activities in Connection with the Fraud, Waste, and Abuse Detection, Prevention, and Correction Program

Hometown. HQH.700 - Provider Clinical Documentation Guidelines

Medicare Financial Management Manual Chapter

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