



103 - FRAUD AND ABUSE

EFFECTIVE DATE: 10/01/94, 10/25/12, 12/01/12

REVISION DATE: 11/01/12, 02/07/13, 03/28/14

STAFF RESPONSIBLE FOR POLICY: DHCM ADMINISTRATION

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DES/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy also applies to subcontractors who are delegated responsibilities under a contract. The purpose of this Policy is to prevent the occurrence of provider and member fraud and abuse of members within the AHCCCS program. The AHCCCS Office of Inspector General (AHCCCS-OIG) is the office of primary responsibility for conducting investigations and inquiries relating to fraud, waste and abuse as it pertains to providers and members.

The objectives of this Policy are to:

1. Facilitate the reporting of potential fraud and abuse cases to AHCCCS for investigation;
2. Require Contractors to work with AHCCCS (e.g., via workgroup) to further develop prevention and detection mechanisms (i.e., best practices) for Medicaid managed care;
3. Explain the role AHCCCS-OIG and the Contractors play in relation to all areas of fraud and abuse within the System;
4. Explain the Contractors' obligations to screen owners, employees and subcontractors.

II. DEFINITIONS

ABUSE OF A MEMBER Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as reference in A.R.S. §§46-451 and 13-3623.

ABUSE BY A PROVIDER Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program 42 C.F.R. 455.2.



FRAUD BY A MEMBER OR PROVIDER

Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law 42 C.F.R. 455.2.

COMPLIANCE OFFICER

The on-site official designated by each Contractor to implement, oversee and administer the Contractors' compliance program including fraud and abuse control. The Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

CREDIBLE ALLEGATION OF FRAUD

A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

1. Fraud hotline complaints;
2. Claims data mining, and
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis 42 C.F.R. 455.2.

PROVIDER

Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901.

III. POLICY

A. PREVENTION/DETECTION

The Contractor shall have in place internal controls, policies and procedures that are capable of preventing, detecting, and reporting fraud and abuse activities. For example, operational policies and controls such as claims edits, prior authorization, utilization and quality review, provider profiling, provider education, post-processing review of claims, adequate staffing and resources to investigate unusual incidents, and corrective action plans can assist Contractors in preventing and detecting potential fraud and abuse activities.



More detailed descriptions of the controls that the Contractor should consider are contained in Attachment A, AHCCCS Contractors Fraud and Abuse Prevention/Detection Summary.

B. REPORTING

If a Contractor discovers, or is made aware, that an incident of potential/suspected fraud and abuse has occurred, the Contractor shall immediately report the incident to AHCCCS by completing the confidential Attachment B, AHCCCS Referral for Preliminary Investigation form. Timely reporting of fraud and abuse improves the likelihood of a successful investigation and prosecution.

The Contractor shall refrain from recoupment or other offset remedies against a provider upon the referral to AHCCCS-OIG of a suspected provider fraud case. AHCCCS-OIG will contact the Contractor when the investigation concludes and will advise the Contractor as to whether recoupment or other offset remedies at the Contractor level are appropriate and approved.

The same form shall be used for abuse of member referrals as well as referrals for provider and member fraud.

1. Abuse of Member Referrals

The form and its attachments shall be submitted to:

AHCCCS, Division of Health Care Management
Clinical Quality Management Unit
701 E. Jefferson, Mail Drop 6700
Phoenix, AZ 85034
FAX (602) 417-4162
Secure email: CQM@azahcccs.gov

2. Fraud by Providers or Members

The form and its attachments shall be submitted to:

AHCCCS, Office of Inspector General
701 E. Jefferson, Mail Drop 4500
Phoenix, AZ 85034
FAX (602) 417-4102

The Contractor may also submit Reports of Fraud, Abuse of the Program or Abuse of a Member, through the forms provided on AHCCCS Public Website at:

<http://www.azahcccs.gov/fraud/Default.aspx>



All pertinent documentation and/or investigative reports that would assist AHCCCS in its investigation shall be attached to the forms.

In the event that AHCCCS-OIG, either through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. Furthermore, the Contractor is fully subrogated to AHCCCS for all civil recoveries.

C. Contractor Compliance Officer Responsibilities Related to Fraud and Abuse

1. Oversee, monitor and be the focal point for the Contractor's compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting such as provider registration, prior authorization and contracts,
2. Maintain and monitor a tracking system of fraud and abuse,
3. Have the authority to independently refer potential member and provider fraud and abuse cases to AHCCCS,
4. Be an on-site management official who reports directly to the organization's CEO, CFO, COO or equivalent, on a regular periodic basis, regarding all fraud and abuse issues including policy matters, cases and training,
5. Have direct access to the CEO and/or the governing body, senior management and legal counsel,
6. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation,
7. Ensure an internal reporting procedure that is well defined and made known to all employees,
8. Periodically review and revise the fraud and abuse policies to meet changing regulations or trends,
9. Regularly attend and participate in AHCCCS, Office of Inspector General work group meetings,
10. Respond promptly to requests for information from the AHCCCS Office of Inspector General,



11. Follow the AHCCCS requirements when AHCCCS-OIG suspends a provider due to a credible allegation of fraud,
12. Cooperate with AHCCCS-OIG regarding any suspected cases of member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702,
13. Ensure that the Contractor is in compliance with its federal and contractual obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion Checks, and Criminal Convictions Checks, and
14. Complete Attachment C, Annual Attestation of Disclosure of Ownership & Control and Disclosure of Information on Persons Convicted of a Crime and submit to AHCCCS.

D. AHCCCS-OIG RESPONSIBILITIES RELATED TO FRAUD AND ABUSE

1. Investigate all cases of suspected member and provider fraud, under the authority of A.R.S. §§36-2918 and 36-2905.04,
2. Issue Civil Monetary Penalties pursuant to A.R.S. §36-2918 and A.A.C. R9-22 Article 11,
3. Oversee, monitor and be the focal point for the AHCCCS' compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting in areas such as provider registration, claims processing and contracts,
4. Maintain and monitor a tracking system of fraud and abuse,
5. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation,
6. Suspend providers when there is a credible allegation of fraud,
7. Interact and work cooperatively with the Contractors to combat fraud, waste and abuse at all levels in the System,
8. Interact and work cooperatively with other law enforcement agencies in the prevention and detection of fraud, waste and abuse,
9. Investigate cases of potential member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702,



10. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of providers to ensure their compliance, and
11. Ensure that AHCCCS is in compliance with its federal obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion Checks, and Criminal Convictions Checks, and all other federal requirements related to Provider Screening and Enrollment.

In addition to the specific requirements stated above, it is required that the Contractor be in compliance with all State and Federal regulations related to fraud and abuse not directly detailed in this Policy.

IV. References

- Section 1903(q) of the Social Security Act
- A.A.C. R9-22 Article 11
- A.A.C. R9-22-702
- A.R.S. §46-451
- A.R.S. §13-3623
- A.R.S. §36-2918
- A.R.S. §36-2905.04
- A.R.S. §36-2903.01(L)A.R.S. §36-2901
- 42 C.F.R, 455.2
- State Medicaid Director Letter 09-001
- State Medicaid Director Letter 08-003
- Deficit Reduction Act, Section 6032
- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- DES/CMDP Contract, Section D
- Attachment A, AHCCCS Contractors Fraud and Abuse Prevention/Detection Activities Summary
- Attachment B, AHCCCS Referral for Preliminary Investigation
- Attachment C, Annual Attestation of: Disclosure of Ownership & Control and Disclosure of Information on persons Convicted of a Crime



**ATTACHMENT A, AHCCCS CONTRACTORS FRAUD AND ABUSE PREVENTION-
DETECTION ACTIVITIES SUMMARY**

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY



ATTACHMENT B, AHCCCS REFERRAL FOR PRELIMINARY INVESTIGATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY



**ATTACHMENT C, ANNUAL ATTESTATION OF: DISCLOSURE OF OWNERSHIP & CONTROL AND
DISCLOSURE OF INFORMATION ON PERSONS CONVICTED OF A CRIME**

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY