COMMUNITY FIRST HEALTH PLANS
PLAN TO PREVENT
FRAUD, WASTE, AND ABUSE

September 1, 2019 through August 31, 2020

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Introduction

This document summarizes the plan developed by Community First Health Plans, Inc. (CFHP) in response to 1 TAC 353 (F) regarding the establishment and operation of a Special Investigation Unit (SIU) by Managed Care Organizations.

Items covered in this document include procedures for detecting, investigating and preventing possible acts of fraud, waste, or abuse by providers and recipients; procedures for referring possible acts of fraud, waste, or abuse for investigation to CFHP Coding and Documentation (CDU); reporting fraud, waste, and abuse to State of Texas and federal agencies; training company personnel and educating recipients and providers to prevent fraud, waste, and abuse; identification of designated personnel responsible for compliance with the rules; and advertising and marketing and other provisions of the plan.

CFHP recognizes detection, investigation and prevention of fraud, waste, and abuse is vital to maintaining an affordable health care system. CFHP has mounted a sincere effort to limit fraud, waste, and abuse through the efforts summarized in this document.

CORPORATE STATEMENT:

SPECIAL INVESTIGATION UNIT

CFHP is committed to protect and preserve the integrity and availability of health care resources to our recipients, our healthcare partners and the general community. CFHP performs these activities through its Coding and Documentation Unit (CDU). The CDU works together with Code editing vendors to detect, prevent and eliminate fraud, waste, and abuse at the provider, recipient and health plan level. CFHP trains employees, contractors and agents to identify and report possible acts of fraud, waste, and abuse. When such acts are identified, CFHP seeks effective remedies to identify overpaid amounts; prevent future occurrences of fraud, waste, and abuse; and report offenses to the appropriate agencies.

COMPLIANCE COMMITTEE

Community First Health Plans has established a Compliance Committee consisting of Senior Leadership, Compliance Managers and Manager of the Coding and Documentation Unit (CDU). The Director of Compliance and Regulatory Affairs serves as the chair of the Compliance Committee. Members of the Board of Directors of CFHP may, at their discretion, attend Compliance Committee meetings.

The Compliance Committee is viewed by CFHP as an integral part of the corporate commitment to compliance. The fulfillment of the duties and responsibilities of each member of the Compliance Committee will help insure CFHP adheres to its corporate commitment to abide by state and federal regulations governing legal and ethical business operations and interactions.

Section (1) Procedures for detecting possible acts of fraud, waste, or abuse by providers

The CDU's procedures for detecting possible acts of fraud, waste, or abuse by CFHP providers include:

Audits

The CDU performs audits to monitor compliance and assist in detecting and identifying possible Medicaid/CHIP program violations and possible fraud, waste, and abuse overpayments through:

- Data matching – procedures, treatments, supplies, tests, and other services, as well as diagnosis billed, are compared for reasonableness using available sources including the American Medical Association (AMA) and the Centers for

Medicare and Medicaid Services. Comparisons include age, gender, and specialty when applicable.

- Analysis – inappropriate submissions of claims are evaluated using software-automated analysis. A comparison of providers' activities lists outliers based on particular specialty and across specialties and includes procedures, modifiers, and diagnosis.
- Trending and Statistical Activities – The CDU uses software to analyze provider utilization and identifies unusual trends in weekly, monthly, and yearly patterns.

Monitoring
The CDU monitors patterns of providers, pharmacies, subcontractors and facilities submitting claims. Through various reports, outlier providers may be monitored through claims submissions and utilization. Providers flagged for specific payment patterns are also examined for other flags to obtain an overall profile. Recipients with flags will be examined for other flags as well and to evaluate patient-provider relationships.

Hotline
CFHP maintains an anti-fraud hotline, at (210)-358-6332 to allow reporting of potential or suspected violations of fraud, waste, and abuse by members, providers and employees. Messages left on the hotline are answered by CDU personnel within two business days. The hotline number is printed on appropriate member and provider communications and published on the CFHP web site. The hotline number is also included in CFHP provider and member handbooks. A toll-free hotline is also available for reporting suspected violations. (1.877.225.7152)

The CDU maintains a log to record calls, the nature of the investigation, and the disposition of the referral.

Random Payment Review
The profiling and statistical analysis is performed on random selection of claims submitted by providers for reimbursement by varying criteria to detect potential overpayment. The queries include a random function to create the reports on different blocks of data and apply them toward flagged claims.

Pre-payment Review
CFHP may identify providers with high utilization patterns or services that may be at risk for improper billing and/or upcoding and place those providers/services on pre-payment review. Claims are reviewed along with the medical record to verify if the service was billed appropriately, prior to payment.

Edits
CFHP utilizes claim-editing software or programs to prevent payment for fraudulent or abusive claims. It is an established and widely used clinically based auditing software system verifying the coding accuracy of professional service claims. These edits include

specific elements of a claim such as procedure, modifier, diagnosis, age, gender, &/or dosage.

Additional edits published by the Center for Medicare and Medicaid (CMS) are also applied during claims processing to prevent payment of incorrect code pairs and units of service errors and/or abusive claim submissions. These edits include the National Correct Coding Initiative (NCCI) and the Mutually Exclusive Edits (MUE).

Verification of services received

CFHP utilizes various methods to verify from members whether services billed were actually received or performed. Methods may include the following, but is not limited to:

- Member surveys initiated by other activities such as:
- Timed services reports
- Provider investigations
- Durable medical equipment delivery receipts
- Random splash screens surveys to members utilizing HealthX web portal

Section (2)

Procedures for investigating possible acts of fraud, waste, and abuse by providers

The CDU conducts preliminary investigations related to possible acts of fraud, waste, and abuse by providers within 15 working days of identification or report of the suspicion or allegation. Information and evidence is gathered from relevant internal and external sources.
The CDU is authorized to query industry/public databases and other commercial/public information sources when directly related to an investigation or when conducting necessary CDU research.

The preliminary investigation includes the following activities:

- Determine if CFHP has received any previous reports of incidences of suspected fraud, waste, or abuse, or conducted any previous investigations of the provider in question. If so, the investigation includes a review of materials related to the previous investigations, the outcome of the previous investigations, and a determination of whether the new allegations are the same or relate to the previous investigation.
- Conduct a review of the provider's billing pattern to determine if there are any suspicious indicators;
- Review the provider's payment history for the past three years to determine if

there are any suspicious indicators; and

- Review the policies and procedures for the program type in question to determine if what has been alleged is a violation.

If the CDU determines that the allegation is sufficient for further action, it shall send

- notice of the violation to MFCU@oag.state.tx.us (email address) and the Office of the Inspector General (OIG) and shall include the following information:
- The provider's name
- Provider's NPI, TPI and TIN
- Information accumulated during the preliminary investigation

  Copies of the relevant policies and procedures

If the preliminary investigation determines suspicious indicators of possible fraud, waste, or abuse, within 15 working days from the conclusion of the preliminary investigation, the CDU selects a sample for further review. The sample consists of a minimum of 50 recipients or 15% of a provider's claims related to the suspected fraud, waste, and abuse.

Within 15 working days of the selection of the sample, the CDU requests medical records and encounter data for the sample recipients.

Within 45 working days of receipt of the requested medical records, the CDU reviews the medical records and claims data in order to:

- Validate the sufficiency of service delivery data and to assess utilization and quality of care;
- Ensure the claims data submitted by the provider is accurate;
- Evaluate if a review of other pertinent records is necessary to determine if fraud, waste, or abuse occurred. If the review of additional records is necessary the CDU conducts such review.

If requested records are not supplied within the specified time frame, CDU initiates the recoupment process and may refer to OIG for failure to supply records.

Section (3)
Procedures for detecting possible acts of fraud, waste, or abuse by recipients

The CDU utilizes software flags for detecting possible acts of fraud, waste, or abuse by CFHP recipients. Flags include:

- Treatments and procedures appearing to be duplicative, excessive or

contraindicated by more than one provider, i.e., same patient, same date-of-service, same procedure code.

- Medications appearing to be prescribed by more than one provider, i.e., same patient, same date-of-service, and same NDC code.
- Recipients appearing to receive excessive medications higher than average dosage for the medication.
- Compare the Primary Care Provider (PCP) relationship code to the recipient to evaluate if other providers and not the PCP are treating the recipient for the same diagnosis.
- Identify recipients with higher than average emergency room visits with a non-emergent diagnosis.

The CDU utilizes CFHP specialty codes to identify psychiatrists, pain management specialists, anesthesiologists, physical medicine, and rehabilitation specialists. The software flags can detect by specialty code possible overuse and/or abuse of psychotropic and /or controlled medications by recipients who are treated concurrently by two or more physicians.

The CDU requests medical records for the recipients in question if claim data review does not clearly determine evidence of overpayment. Upon the receipt of the records from the provider, the CDU reviews the documentation for appropriateness and to determine if it is necessary to seek guidance on appropriate actions such as reporting to the HHSC-OIG and the recovery process if necessary.

Section (4)

Procedures for investigating possible acts of fraud, waste, and abuse, by recipients.

The CDU conducts preliminary investigations related to possible acts of fraud, waste, and abuse by recipients within 15 working days of identification or report of the suspicion or allegation. Investigations are conducted under the guidelines previously described in Section (2).

Preliminary Investigation

The preliminary investigation includes but is not limited to the following:

- Review of acute care and emergency room claims to determine:
  - utilization of non-emergent diagnosis by provider
  - utilization of non-emergent diagnosis by recipient
  - prescription of controlled substances and pain medicine by provider
  - prescription of controlled substances and pain medicine by recipient

- comparison of emergency procedures by physicians and facility for possible up coding
- outliers in number of visits to the emergency room by patient

- Review of pharmacy claim data is performed for suspicious indicators such as:
  - higher than average or excessive use of controlled and non-controlled drugs
  - higher than average prescriptions or inconsistent drugs based on the NDC and diagnosis codes
- If necessary pharmacy claim data reviews are assisted by the CFHP Pharmacy Benefit Manager (PBM) to determine if suspicious indicators warrant further investigation.
- Comparison of procedures, tests, supplies, modifiers, and diagnosis submissions across lines of business may be performed.

Section (5)
Internal procedures for referring and reporting possible acts of fraud, waste, or abuse and the mandatory reporting of possible acts of fraud, waste, and abuse by providers or recipients to the Texas Health and Human Services Commission-Office of the Inspector General (HHSC-OIG) and other appropriate agencies

The responsibility and authority at CFHP for reporting investigations resulting in a finding of possible acts of fraud, waste, and abuse to the Texas Health and Human Services Commission-Office of Inspector General (HHSC-OIG) and other appropriate agencies is:

Name:	**Laura Ketterman**
Title:	**Director Compliance and Regulatory Affairs, Compliance Committee Chair**
Street Address:	**12238 Silicon Drive, Suite 100**
City State Zip	**San Antonio, TX 78249**
Office Phone:	**(210) 510-2482**
Fax:	**(210) 358-6306**
Email:	**lketterman@cfhp.com**

This individual has:

- Direct access to the organization's governing body, the CEO and other senior management, and legal counsel**;**
- The authority to review documents and other information relevant to fraud, waste,

and abuse compliance activities; and

- Maintains sufficient resources to conduct required activities.

To inform CFHP staff on how and what must be reported to the CDU, regular education and training programs have been developed and implemented. Elements of the program are:

- CFHP employees must attend annual training defining fraud, waste and abuse and defines the process for reporting to the CDU;
- The CDU disseminates compliance information on an ongoing basis using the intranet, staff meetings or other appropriate media.
- Standard paper and electronic formats are utilized and distributed to employees for the reporting of suspected acts of fraud, waste, and abuse. Training is available if employees require instruction on the procedures to be followed.
- A toll-free hotline (1.877.225.7152) has been established and its existence publicized to promote its use by staff, providers, recipients and other individuals to report suspected acts.

Special emphasis is placed on defining specific acts of fraud, waste, and abuse:

Fraud is an intentional representation an individual knows to be false or does not believe to be true and makes, knowing the representation could result in some unauthorized benefit to himself/herself or some other person.

Acts of **waste** are defined as activities involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent but the outcome of poor or inefficient methods results in unnecessary costs to the Medicaid/CHIP program.

Acts of **abuse** are defined as activities unjustly enriching a person through the receipt of benefit payments but where the intent to deceive is not present or an attempt by an individual to unjustly obtain a benefit payment.

CFHP considers previous educational efforts when determining intent. Intentional misrepresentation, intent to deceive and or attempting to obtain unjust benefit payments is not considered unless there is documented previous education in writing or in person by CFHP regarding the same or similar adverse audit findings or there is obvious program violations.

Fraud may be defined as having occurred when a person:

(1) Knowingly or intentionally makes or causes to be made a false statement or misrepresentation of a material fact on an application for a contract, benefit, or payment under the Medicaid/CHIP programs; or makes or causes to be made a false statement or misrepresentation of a material fact that is intended to be used to determine a person's eligibility for a benefit or payment under the Medicaid/CHIP programs;

(2) Knowingly or intentionally conceals or fails to disclose an event:

- that the person knows affects the initial or continued right to a benefit or payment under the Medicaid/CHIP programs to him or herself or another person on whose behalf the person has applied for a benefit or payment or is receiving a benefit or payment; or
- to permit a person to receive a benefit or payment that is not authorized or that is greater than the payment or benefit that is authorized;

(3) Knowingly or intentionally applies for and receives a benefit or payment on behalf of another person under the Medicaid/CHIP programs and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received;

(4) Knowingly or intentionally makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:

- The conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid/CHIP programs, including certification or recertification as a hospital, a nursing facility or skilled nursing facility; a hospice; an intermediate care facility for the intellectually disabled; an assisted living facility; or a home health agency; or
- information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid/CHIP programs;

(5) Except as authorized under the Medicaid/CHIP programs, knowingly or intentionally charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid/CHIP programs, a gift, money, a donation, or other consideration as a condition to the provision of a service or continued service to a Medicaid/CHIP recipient if the cost of the service

provided to the Medicaid/CHIP recipient is paid for, in whole or in part, under the Medicaid/CHIP programs;

(6) Knowingly or intentionally presents or causes to be presented a claim for payment under the Medicaid/CHIP programs for a product provided or a service rendered by a person who:

- is not licensed to provide the product or render the service, if a license is required; or
- is not licensed in the manner claimed;

(7) Knowingly or intentionally makes a claim under the Medicaid/CHIP programs for:

- A service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;
- A service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or
- A product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;

(8) Makes a claim under the Medicaid/CHIP programs and knowingly or intentionally fails to indicate the type of license and the identification number of the licensed health care provider who actually provided the service;

(9) Knowingly or intentionally enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid/CHIP programs or a fiscal agent; or

(10) A managed care organization that contracts with the Health and Human Services Commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid/CHIP programs knowingly or intentionally:

- Fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract;
- Fails to provide to the commission or appropriate state agency information required to be provided by law, commission or agency rule, or contractual provision;
- Engages in fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid/CHIP programs in the

organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid/CHIP programs; or

- Obstructs an investigation by the attorney general of an alleged unlawful act.

CFHP training and educational materials include the requirement that any act of fraud, waste, and/or abuse identified by a CFHP officer, director, manager or employee will be reported to the CDU within 24 hours of the identification, referral or reporting of a suspected act .

CFHP communicates to employees, enrollees, and providers, written confidentiality and non-retaliation policies to encourage the communication and reporting of suspected or potential violations through its annual training, Compliance Plan, Policies and Procedures, Provider and Member Newsletters and periodic training throughout the year.

CFHP communicates policies regarding disciplinary action for employees who have failed to comply with the organization's standard of conduct, policies and procedures, contract requirements, Federal and/or State laws, or those who have engaged in otherwise illegal or unethical conduct related to the fraud, waste, and abuse compliance.

Internal procedures for the CDU to report investigations resulting in a finding of fraud, waste, or abuse, are assigned to a CFHP officer or director:

The CDU Manager will report to the Director Compliance and Regulatory Affairs when the results of an investigation conclude there is reasonable belief an act of fraud, waste, or abuse has occurred. Reasonable belief is defined as possessing knowledge of facts, although not amounting to direct knowledge, would cause a reasonable person, knowing the same facts, to reasonably come to the same conclusion. Evidence that may be used to establish and support reasonable belief includes:

- Billing records
- Claim copies
- Claim histories
- Correspondence
- Data analysis
- Investigator affidavits
- Medical records
- Enrollment applications
- Witness statements
- Any other information reasonably related to the investigation.

Acts reasonably believed by the CDU to constitute acts of fraud, waste, or abuse, will be reported to the Director Compliance and Regulatory Affairs within 15 working days of the determination.

Utilizing the fraud referral form, the designated Fraud Officer or designee reports and refers possible acts of fraud, waste, and abuse to the HHSC-OIG or other appropriate agencies within 30 working days of receiving the reports of possible acts of fraud, waste, and abuse from the CDU.

The report and referral includes an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of interviews conducted; the encounter data submitted by the provider for the time period in question; and supporting documentation obtained as the result of the investigation.

An expedited referral is required and will be made by the CDU when there is reason to believe delay may result in:

- Harm or death to patients; or
- Loss, destruction or alteration of valuable evidence; or
- A potential for significant monetary loss may not be recoverable; or hindrance of an investigation or criminal prosecution of the alleged offense.

Monthly Reports

CDU will submit a MCO monthly open case list report to OIG MPI. The report will be in a format specified by HHSC OIG.

The report will include a report of identified overpayments, pre-payment reviews not paid and other recoupments by the MCO.

The monthly report will include open and recently completed cases.

The CDU provides OIG MPI the monthly report electronically by the due date required by OIG MPI.

The CDU should not initiate any recovery action on cases over $100,000.00 reported to OIG until the following occurs:

- OIG responds that it will not accept the case
- The ten (10) business day deadline for responding elapses.
- If OIG responds within ten (10) business days that it intends to recoup any overpayments, the MCO-CDU should not take any further collection action against the provider until OIG proceedings have been exhausted.
- If OIG does not notify CFHP to abate collections within ten business days, the CDU may collect any overpayments it has identified.

- In the event OIG later decides to accept the case for additional investigation and enforcement, OIG will offset any identified overpayments by the amount that has already been recouped the CDU.
- If CDU initiates enforcement action after ten (10) business days or after OIG has declined to accept the case referral, it must report any recoveries to OIG MPI on the monthly case report.

Section (6)
Procedures for Determining General Overpayments

The following types of reviews are performed to assist in the determination of overpayments:

- Compliance audits
- Monitoring of service patterns
- Random payment review of claims
- Routine validation of claim payments
- Pre payment review
- Review of hospital medical records (including physician orders, progress notes, nursing notes, operative notes and medication administration records)
- Focused reviews
- Review of claim edits or other evaluation techniques
- Itemized hospital bill reviews
- Supply and/or implant invoice

Findings considered general overpayments include the following:

- Billing errors
- Insufficient documentation to support billed charges
- Inappropriate use of modifiers
- Incorrect billing provider
- Duplicates
- Billed service not included in authorization
- Matching of diagnosis and procedure codes
- Unbundling of services, procedures and/or supplies
- Claim processing errors

Section (7) Procedures for Overpayment Recovery Process

REPORTING AND RETURNING OF OVERPAYMENTS

Patient Protection and Affordable Care Act ("PPACA §6402(a)") requires that Medicaid overpayments be "reported and returned" **within 60 days** after they are "identified". When a provider has "identified" an overpayment, the provider has the responsibility to report and return the overpayment to Community First Health Plans and notify Community First Health Plans in writing of the reason for the overpayment.

The failure to timely report and/or return any Medicaid overpayments, identified by either providers or Community First Health Plans, can have severe consequences, including termination from the Provider Network, potential liability under the False Claims Act, as well as the imposition of civil monetary penalties and exclusion from the Medicare and Medicaid programs. "PPACA §6402(d) (2), and 6502".

Community First Health Plans will notify providers of any identified overpayments within 60 calendar days of the findings. Refunds are due within 60 calendar days of the refund request. Refunds not received or appealed in a timely manner may be recouped. Community First Health Plans may analyze claim data or validate services for improper payments/overpayments up to a maximum of a three (3) year period from the date of the received claim(s). "PPACA §6411".

Recovery Process:

CFHP may recover any identified overpayment up to $100,000.00.
The CDU has established the following process regarding the recovery of overpayments discovered through various activities including but not limited to focus or random audits, appeals, compliance reviews and/or investigations including preliminary investigations.

Medicaid/CHIP program overpayments will be processed in the following manner:

- Notification of overpayments will be in writing and include the following:
- Specific claim(s) number(s) and amounts overpaid
- The notice of the physician's or provider's right to appeal
- Describe the method and due date by which the refund is expected
- Describe actions that occur if overpayment is not refunded.

Identified overpayments greater $100,000.00:

Overpayment amounts, due to potential fraud, that exceed $100,000.00 are referred to OIG-MPI. The OIG will notify CFHP CDU within ten (10) business days of the referral if OIG will accept referral for further investigation. CFHP CDU shall not begin recoupment actions. CFHP CDU shall not begin any recoupment actions until after the tenth (10) business day from the referral to OIG-MPI, unless notified by OIG case is accepted.

Overpayment amounts that exceed $100,000.00 will be reported on the monthly "MCO Open Case List" and sent to the OIG-MPI and the Office of Attorney General Medicaid Fraud Control Unit.

Identified overpayments less than $100,000.00:

Overpayment amounts that are $100,000.00 or less may be recouped by CFHP CDU. Amounts less than $100,000.00 will be reported on the monthly "Open Case List".

Non voluntary repayment of overpayments may result in any or a combination of the following actions:

- Recoupment of overpayment from future claims
- Payment hold
- Termination from the Community First Health Plans Network
- Referral to the appropriate regulatory agency
- Exclusion from Medicare/Medicaid

Medicaid program overpayment appeal process:

A physician or provider may appeal a request for refund by providing written notice of disagreement of the refund request not later than the due date of the overpayment notification.

Upon receipt of written notice, the CDU shall begin the appeal process as provided in the contract with the physician or provider.

A refund will not be recouped until the after the sixtieth (60^{th}) day after overpayment notification or provider has made arrangements in writing for payment with the CDU prior to the sixtieth (60^{th}) day of the overpayment notification

The appeal process does not apply in cases of fraud or a material misrepresentation by a provider. Fraud is considered and noted as intentional after a provider has been previously educated in writing or in person by CFHP regarding the same or similar audit, review or investigational findings or there is reasonable clear evidence of intent.

Section (8)

Procedures for educating recipients, providers and training personnel to prevent fraud, waste, and abuse

To establish effective internal procedures for referring possible acts of fraud, waste, or abuse to the CDU, regular education and training programs have been developed and implemented for CFHP employees.

- CFHP employees are required to attend annual training emphasizing the organization's commitment to Federal and State statues and requirements related to fraud and abuse. Training is specific to the area of responsibility for the staff receiving the training and contains examples of fraud, waste, or abuse in their area of specialization.
- New CFHP staff receive training on fraud, waste, and abuse within 90 days of employment;
- The CDU disseminates compliance information on an ongoing basis using monthly newsletters, bulletins, websites or other appropriate media.
- Special emphasis is placed on defining acts of fraud, waste, and abuse and how to report suspected fraud, waste, and abuse.

CFHP has established several mechanisms used by CFHP employees for the reporting of suspected acts of fraud, waste, and abuse. Training is conducted to instruct employees on the procedures to be followed. The Suspicious Activity Report (SAR) is available to CFHP employees on the CFHP intranet. Two internal numbers are distributed to all CFHP employees to report any suspicious activity. A CFHP employee may also send an internal email to either the Fraud Officer or members of the CDU.

A fraud hotline has been established and the number has been published in both the member and provider manuals. Newsletters as well are posted on the CFHP website to promote its use to providers, recipients and other individuals for reporting suspected acts.

The CDU provides education and training for recipients, providers and CFHP employees to prevent fraud, waste, and abuse.

Recipient and provider education

- Recipients and providers are provided fraud, waste and abuse education through a variety of avenues such as CFHP web site, member and provider newsletters, provider manuals, and member handbook. The information contained in the material includes the definitions of fraud, waste, and abuse and how to report fraud, waste, and abuse.

Training of CFHP personnel with **direct** Medicaid/CHIP involvement to prevent fraud, waste, and abuse

On an annual basis, and within 20 working days of changes made to policy and/or procedure the CDU provides fraud, waste, and abuse training to CFHP employees who are directly involved in any aspect of Medicaid/CHIP. Training is required for individuals responsible for data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality management, and marketing. The training is specific to the area of responsibility and contains examples of fraud, waste, or abuse to the staff's particular area of responsibility.

The anti-fraud training program is conducted to develop and improve the anti-fraud awareness skills of CFHP employees. In addition to annual sessions and within 20 working days of changes made to policy and/or procedures, training is also available on an ad hoc basis when requested by any CFHP department or internal or external customer.

The training includes with relevant examples the following general topics:

- The function and purpose of the CDU
- Review of the written procedures established by the CDU regarding the identification, documentation and reporting of suspected fraud, waste, and abuse to the CDU
- Instruction and distribution of standardized referral forms to report incidents of suspected fraud, waste, and abuse to the CDU
- Necessity for expedited referrals in certain circumstances
- Statutory and regulatory definitions of fraud, waste, and abuse
- Responsibility of the individual to report suspected fraud, waste, and abuse
- Responsibility of other individuals to report suspected fraud, waste, and abuse
- Identification and recognition of red flags or red flag events
- Common recipient fraud, waste, and abuse schemes
- Presentation of specific requirements for mandatory fraud, waste, and abuse reporting to State and Federal agencies.

Specific training includes relevant examples of the following topics:

<u>Data Collection</u>

- Peer group provider comparisons by service type
- Peer group provider comparisons by type and quantity of services per patient
- Peer group provider comparisons by diagnosis
- High percentage of charges for most complicated level of subsequent hospital care
- Billing by physicians for routine dialysis procedures

- Duplicate professional/facility billings for emergency room and other hospital services

Provider Enrollment

- Licensure requirements
- Prior disciplinary actions by state licensing boards
- Exclusion from federal programs
- PO Box or mail service location is identified as place of business
- Claims for services submitted within dates of licensure suspension

Provider Disenrollment

- Elements of due process
- Mandatory reporting of action

Encounter Data

- Peer member group analysis by service type
- Peer member group analysis by type and quantity of services per member
- Peer member group provider analysis by diagnosis
- Underutilization of services
- Excessive referrals to specific providers

Claims Processing

- Patient states service was not provided
- Provider's signature is missing from paper claim form or medical record
- Previously rejected claim is resubmitted with different diagnosis, billed amount and/or procedure code
- Provider states service was not provided after receiving remittance advice

Utilization Review

- High member utilization of acute care, emergency and urgent care facilities
- Provider's medical credentials do not match type of service provided
- Excessive number of treatments for single date of service
- Same treatments are provided to multiple family members on same date of service
- Claims paid for non-covered benefits

Appeals

- Diagnosis does not match treatment
- Services were not provided as charged
- Medical record suggests an inadequate level of care was provided

Grievances

- Excessive number of complaints regarding a particular provider

Quality Management

- Services are not documented in medical record
- Medical record does not substantiate submitted services

Marketing

- Advertising and marketing materials, and any other correspondence going to members, must be approved by HHSC. No documents can be subsequently altered without HHSC approval.
- Materials related to fraud, waste, and abuse activities will support the Texas Health and Human Services Commission's objective to bring the public and private sectors together to reach the mutual goals of reducing healthcare fraud and abuse; improving CFHP's operational quality; improving the quality of healthcare; and reducing overall healthcare costs.

Training of CFHP personnel with **indirect** Medicaid/CHIP involvement to prevent fraud, waste, and abuse

General training is provided to CFHP staff not directly involved in Medicaid/CHIP operations and to other individuals employed by CFHP, specific to the role or function of the department.

The training includes:

- The function and purpose of the CDU
- Introduction and review of the written procedures established by the CDU regarding the identification, documentation and reporting incidents of suspected fraud, waste, and abuse to the CDU
- Instruction on standardized referral forms to report incidents of suspected fraud, waste, and abuse to the CDU
- Statutory and regulatory definition of fraud, waste, and abuse

- Responsibility of the individual to report suspected fraud, waste, and abuse
- Responsibility of other individuals to report suspected fraud, waste, and abuse
- Identification and recognition of red flags or red flag events
- Common recipient fraud, waste, and abuse schemes including characteristics of bill alteration; identification of fabricated billings; and identification of misdirection of payment schemes
- Common provider fraud, waste, and abuse schemes including characteristics of false claims; billings for services not provided; and examples of unethical billing practices including double billing, upcoding and unbundling
- Examples of current fraud, waste, and abuse schemes and presentation of new and emerging insurance trends
- Presentation of specific requirements for mandatory fraud, waste, and abuse reporting to State and Federal agencies
- Updates of changes made to policy and/or procedure regarding fraud, waste, and abuse are provided within 20 working days of the change

The CDU maintains a training log to document training pertaining to fraud, waste, and/or abuse related to Medicaid/CHIP programs. The log includes the name of staff attending the training, the trainer and the date and length of the training. The type of media will also be identified on the log and paper copies of material provided in training sessions will also be maintained with the log.

The log will be provided immediately upon request to any of the following parties:

- Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG)
- Office of the Texas Attorney General's (OAG)-Medicaid Fraud Control Unit (MCFU) and
- Texas OAG-Civil Medicaid Fraud Division (CMFD)
- United States Health and Human Services-Office of Inspector General (HHS-OIG).
- Texas Department of Insurance
- Texas Health and Human Services Commission (HHSC)

Written standards of conduct, and written policies and procedures include a clearly delineated commitment from CFHP and the CDU for detecting, preventing and investigating fraud, waste, and abuse is documented by the above Corporate Statement and by the development of CDU Policies and Procedures.

Policy and Procedures

The CDU staff with the designated Fraud Officer is jointly responsible for compiling, maintaining and distributing the CDU Policy and Procedures.

The policies describe the procedures used by the CDU for its general operations; demonstrate compliance with state and federal requirements; and serve as a training resource for new members of the CDU.

Section (9)

Notice to Recipients, Providers, Employees, Contractors and Agents Regarding the Deficit Reduction Act of 2005 Section 6032.

Consistent with Section 6032 of the Deficit Reduction Act of 2005, CFHP has established guidance to educate recipients, providers, employees, contractors and agents regarding the reporting of fraud, waste, or abuse. For clarification purposes, contractors and agents are defined by CMS as "one which, or one who, on behave of CFHP, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring health care".

The following defines the False Claims Act and Texas State Whistleblower Act which allows American citizens the right and responsibility to report or file suit regarding federally funded fraudulent claims. In addition, these laws outline the federal penalties for submitting false claims and provide protection to individuals who report any such violations.

FALSE CLAIMS ACT

The **False Claims Act** (31 U.S.C. § 3729 *et seq.*, also called the "**Lincoln Law**") allows American citizens, whether affiliated with the government or not, to file actions against federal contractors claiming fraud against the government.

The False Claims Act was passed by Congress to prevent the United States Government from paying federal funds for fraudulent claims involving goods and services. For Community First Health Plans (CFHP), this includes submitting false information to third party payors, such as Medicaid and Medicare, in order to receive a higher reimbursement. Examples of this include upcoding (i.e., coding a higher DRG than the documentation supports), lab unbundling (i.e., charging separately for procedures usually charged as one procedure), billing for services not actually rendered and duplicate billing.

The False Claims Act outlines the federal penalties for submitting false claims, as well as protections granted to an individual who reports a violation.

RULES AND PROCEDURES

A civil action involving false claims must be made within six years of the date the violation occurred. The government official notified of the civil action has up to three years to act after learning of the allegation. No action can be taken more than 10 years from the date the violation took place.

A false claims action can be filed in any judicial district where the defendant can be found, resides or transacts business.

The Attorney General, believing an individual has information pertaining to the false claims investigation, may serve the individual with a civil investigative demand requiring that the person:

- provide any documentation materials for inspection and copy
- answer any written interrogation about the materials
- give oral testimony on the materials or
- furnish any combination of the three listed above

PROTECTIONS

Any person who commits a violation will have a reduced penalty if:

- the person provides the Attorney General's office with the information known about the violation within 30 days,
- the person fully cooperates with any government investigation involving the violation, or
- the person comes forward in good faith and is not aware an investigation was pending

Private individuals can file civil action (a lawsuit) against a firm participating in fraudulent activity on behalf of themselves and the United States Government. This civil action allows for an employee to file a lawsuit against his or her employer if the employer is fraudulently billing the federal government. This action is called a qui tam lawsuit. If the government proceeds with the action and collects, the individual is eligible to receive 15-25% of the settlement or proceeds of the action. The amount, if any, is dependent on the extent the individual contributes to the prosecution of the action.

However, the court may reduce the whistleblower's share of the proceeds if the court finds the whistle blower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

PENALTY

The penalty for making a false claim is adjusted annually.
SOURCE: (28 CFR §85.5(31 U.S.C3729(A))

TEXAS STATE WHISTLEBLOWER ACT

Under the False Claims Act, any employee who is fired, demoted, suspended, harassed or otherwise discriminated against by his or her employer because of a claim, lawfully filed by the employee, is protected by the federal government and will be entitled to reinstatement, back pay and compensation for damages resulting from the discrimination.

CFHP employees are also protected by the Texas state law from retaliation for reporting a violation of law to government entities. According to this law

- CFHP may not suspend, terminate or threaten an employee for reporting a violation to a law enforcement authority. CFHP may be held liable for any form of retaliation taken against an employee, student or volunteer who reports fraudulent activity.
- A CFHP employee who is suspended or terminated or has been threatened for reporting a violation is entitled to sue for injunctive relief, actual damages, court costs and reasonable attorney fees. In addition, the employee is entitled to return to the same or an equal position and to payment of lost wages.

- An employee suing CFHP may not recover damages in an amount exceeding $250,000.
- An employee must sue within 90 days of the alleged suspension, termination or threats. The suit must be filed in the district court of the county in which the retaliation took place or in a district court of Travis County.
- A supervisor, who suspends, terminates or makes threats against an employee for reporting a violation to a law enforcement authority can receive a civil penalty up to $15,000.

SOURCE: (TEXAS GOV'T CODE ANN., §554.001-+§554.009)

FALSE CLAIMS ACT AMENDMENT

The Fraud Enforcement and Recovery Act (FERA), signed into law May 20, 2009 amends the False Claims Act (FCA), 31 U.S.C. § 3729 *et seq* expanding the liability exposure of every company doing business with the federal government and of every company supplying goods or services reimbursed by federal government dollars.

FERA substantially broadened the FCA in several fundamental ways:

- FERA imposes FCA liability even if the company that submitted a false claim to a non-government entity did not specifically intend to defraud the government with a section making certain provisions retroactive to June 7, 2008.

- FERA provides a new definition of a "claim" as: “any request or demand, whether under a contract or otherwise, for money or property…whether or not the United States has title to the money or property that is presented to an officer, employee, or agent of the United States; or is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used ***on the Government's behalf or to advance a Government program or interest***, and if the United States Government provides or has provided any portion of the money or property requested or demanded; or will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded. **What this means is parties indirectly receiving government funds may now be liable for FCA violations, even if they never directly present a claim to the government.**
- FERA now defines "obligation" to include "the retention of any overpayment."
- FERA provides that government claims can "relate back" to the time of filing the original *qui tam* action for statute of limitations purposes.
- FERA expands whistleblower protections to now read, "**any *employee, contractor, or agent*** shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment …." (Section 3730(h)).
- FERA allows greater sharing of materials during the “under seal” period following the filing of *qui tam* complaints.

FERA authorizes the Attorney General to share information obtained through Civil Investigative Demands with *qui tam* relators if the disclosure is "necessary as part of any false claims act investigation."

MEDICIAD PAYMENT HOLDS DUE TO CREDIBLE ALLEGATIONS OF FRAUD

On February 2, 2011, the Centers for Medicare & Medicaid Services (“CMS”) revised its regulations to comport with the new Patient Protection and Affordable Care Act (PPACA) provisions. Under 42 C.F.R. §455.23 state Medicaid agencies “must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.”

(a) OIG may impose a payment hold against any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:

(1) is subject to a suspension of payments by the U.S. Department of Health and Human Services for Medicare violations;
(2) commits a program violation;
(3) is affiliated with a person who commits a program violation; or

(4) for any other reason provided by statute or regulation.

(b) OIG imposes a payment hold against a person:

(1) to compel the production records or documents when a request made by a requesting Agency is refused;

(2) when requested by the state's Medicaid Fraud Control Unit; or

(3) upon receipt of reliable evidence that verifies a credible allegation of fraud.

(c) Notice.

(1) Unless OIG receives a request from a law enforcement agency to temporarily withhold notice to a person of payment hold, OIG provides written notice of a payment hold no later than the fifth (5th) business day after the date the payment hold is imposed. A law enforcement agency may request a delay in sending notice for up to 30 days. The request may be renewed up to twice and in no event may exceed 90 days.

(2) Notice of payment hold includes:

(A) a description of the hold;

(B) the basis for the hold;

(D) the duration of the hold; and

(E) a statement of the person's right to request an informal review or an expedited administrative appeal hearing regarding the imposition of the payment hold.

(3) If the payment hold is based on reliable evidence that verifies a credible allegation of fraud, written notice will also:

(A) state that the payments are being suspended according to 42 CFR §455.23;

(B) state the general allegations as to why the payment hold has been imposed;

(C) State that the hold is for a temporary period and will be lifted after either:

(i) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person; or

(ii) legal proceedings related to the person's alleged fraud are completed;

(D) specify the types of Medicaid claims or business units to which the payment suspension is effective; and

(E) inform the provider of the right to submit written evidence for consideration by the agency.

(d) Due process.

(1) A person may request an expedited informal review after receipt of a notice of payment hold in accordance with §371.1613(e) of this subchapter (relating to Informal Review). OIG must receive the written request for the informal review no later than the tenth calendar day after the date the person receives the notice. A request for an informal review does not expand the time allowed to the provider to request an administrative hearing.

(2) Within ten days of receipt of the notice of payment hold, the person receiving the notice may submit to OIG any documentary evidence or written argument regarding whether payment hold is warranted and any related issues to be considered during the informal review. Submission of documentary evidence or written argument, however, is no guarantee that OIG will not ultimately maintain imposition of the hold.

(3) A person may request an expedited administrative appeal hearing after receipt of a notice of payment hold in accordance with §371.1615(d) of this subchapter (relating to Appeals). OIG must receive the written request for an appeal no later than the tenth calendar day after the date the person receives the notice.

(4) If both an informal review and an administrative hearing are requested, the administrative hearing and all pertinent discovery, prehearing conferences, and all other issues and activities regarding the administrative hearing will be abated until all informal review discussions have concluded without settlement or resolution of the issues.

(e) Scope and effect of payment hold.

(1) Once a person is placed on payment hold, payment of Medicaid or other HHS program claims for specific procedures or services and any other payments to the person from an HHS agency will be limited or denied.

(2) After a payment hold is terminated for any reason, OIG may retain the funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.

(3) The payment hold may be terminated or partially lifted upon the following events:

(A) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person if the hold is based upon an allegation of fraud;

(B) Legal proceedings related to the person's alleged fraud are completed if the hold is based upon an allegation of fraud;

(C) The Medicaid Fraud Control Unit asks OIG to lift the hold if the hold is based upon the Unit's request;

(D) The duration of the hold expires if the hold was imposed for a specific, limited time;

(E) OIG and the person have agreed to lift the hold in whole or in part during an informal resolution;

(F) OIG determines in its sole discretion that there is insufficient evidentiary or legal basis for maintaining the hold;

(G) OIG determines in its sole discretion that it is in the best interests of the Medicaid program to lift the hold;

(H) OIG determines that a payment hold would adversely affect clients' access to care;

(I) an administrative law judge or judge of any court of competent jurisdiction orders OIG to lift the hold in whole or in part; or

(J) All proceedings against the provider, including any appeals and judicial review, have been exhausted and all overpayments and other reimbursements are satisfied.

SOURCE: (TEXAS ADMINISTRATIVE CODE, RULE 371.1709)

REPORTING CONCERNS

As stewards of the taxpayer's money, CFHP wants its resources used as economically and efficiently as possible. CFHP encourages employees to use their chain of command when reporting concerns. This means giving their immediate supervisor the opportunity to resolve issues at this level before moving up to the next level. If the employee is not satisfied with the resolution from their immediate supervisor, they are empowered to move up the chain of command until they are assured their concern is resolved.

In addition to the CDU hotline, the CFHP Compliance Department also has a hotline phone number and reporting system for reporting of compliance concerns. Staff may use the Compliance Hotline to report compliance concerns including any of the following areas:

- Violations of applicable laws and regulations
- Violations of CFHP's Code of Conduct policy
- Violations of HIPAA regulations
- Violations of CFHP's and/or UHS' policies
- Concerns about CFHP's or UHS' accounting, internal accounting control or auditing related matters
- Other general compliance concerns or issues

Reports to the Compliance Hotline are confidential. The Compliance Hotline is available 24 hours a day, 7 days a week. Hotline calls are received by the CFHP Privacy Officer. Callers may remain anonymous. CFHP will investigate and conduct follow up, as appropriate, on Compliance Hotline reports. CFHP prohibits retaliation against an individual who makes a report of a suspected compliance or legal issue.

Community First Health Plans (CFHP) realizes that sometimes it is uncomfortable for an employee to report a concern through their chain of command, so other resources are offered:

CFHP CDU HOTLINE	**210-358-6332**
CFHP COMPLIANCE HOTLINE	**210-358-6049**
PROTECTIVE SERVICES	**210-358-2450**
EMPLOYEE COUNSELOR	**210-358-2332**
HUMAN RESOURCES	**210-358-2275**

ADDITIONAL RESOURCES

To demonstrate CFHP's commitment to preventing and detecting errors, fraud, waste, and abuse, additional detailed information regarding state and federal False Claims Act and whistleblower protections is made available through the following resources:

- Updated provider, member and employee handbook
- CFHP website
- CFHP intranet
- New employee hire training
- Annual employee training
- CFHP on-site fraud awareness posters

Section (10) Identification of assigned plan officer

The CFHP individual responsible for carrying out the fraud, waste, and abuse plan is:

Name:	**Laura Ketterman**
Title:	**Director Compliance and Regulatory Affairs, Compliance Committee Chair**
Street Address:	**12238 Silicon Drive, Suite 100**
City State Zip	**San Antonio, TX 78249**
Office Phone:	**(210) 510-2482**
Fax:	**(210) 358-6306**
Email:	**lketterman@cfhp.com**

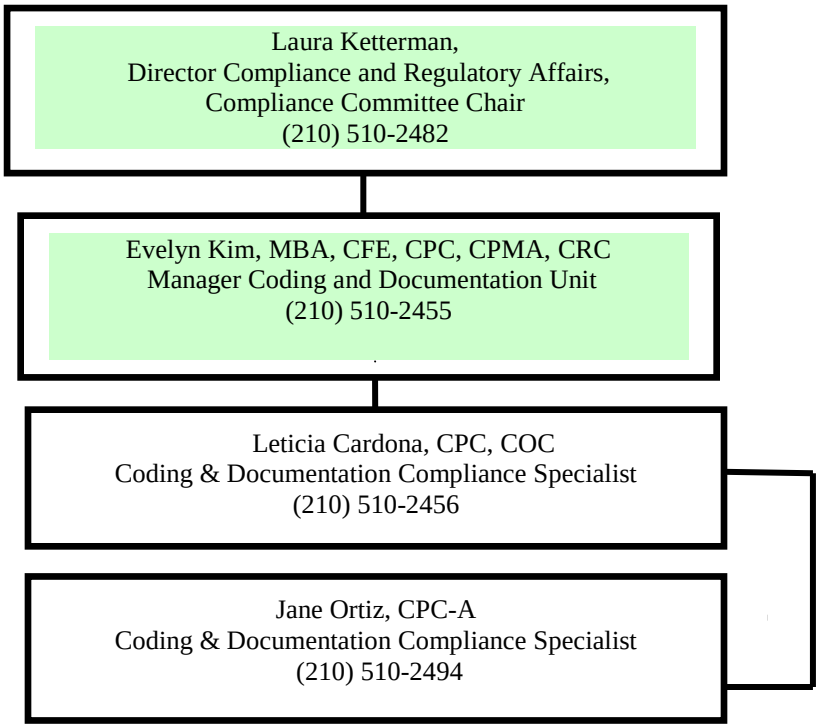
This individual is a member of CFHP executive management. Any personnel changes in this position will be reported to HHSC-OIG within 15 working days of the change.

The CDU individual responsible for carrying out the fraud, waste, and abuse plan is:

Name	**Evelyn Kim**
Title	**Manager, CDU**
Street address	**12238 Silicon Drive, Suite 100**
City State Zip	**San Antonio, Texas, 78249**
Office phone	**(210) 510-2455**
Cell Phone	**(210) 216-8609**
Fax number	**(210) 358-6405**
Email	**Ekim@cfhp.com**

Section (11) Personnel responsible for investigating and reporting possible acts of fraud, waste, and abuse

The CFHP CDU personnel responsible for investigating and reporting possible acts of fraud, waste, or abuse are as follows.



Section (12) Advertising and marketing materials

Advertising and marketing materials utilized by CFHP accurately reflect information about CFHP. Marketing and Advertising materials related to government lines of business are approved by HHSC prior to utilization. CFHP understands marketing materials include any informational materials targeted to recipients.

Advertising and marketing materials related to fraud, waste, and abuse activities support the Texas Health and Human Services Commission's objective to bring the public and private sectors together to reach the mutual goals of reducing healthcare fraud and abuse; improving CFHP's operational quality; improving the quality of healthcare; and reducing overall healthcare costs.

Section (13) Other Provisions

On a monthly basis, the CDU submits to the HHSC-OIG a report listing open cases, investigations conducted resulting in no findings of fraud, waste, or abuse and identified overpayments or recoupments including pre-payment review denials. The report includes the allegation, the suspected recipient's or provider's Medicaid number, the claim number, the source, the time period in question, and the date of receipt of the identification and or reporting of suspected and/or potential fraud, waste, or abuse, the identified overpayment amount and or any comments.

The CDU maintains a log of incidences of suspected fraud, waste, and abuse, received by CFHP regardless of the source. The log contains the subject of the complaint, the source, the allegation, the date the allegation was received, the recipient or providers Medicaid number, and the status of the investigation.

The CDU provides the incident log at a time of a reasonable request to the HHSC-OIG, OAG-MFCU, OAG-CMFD, and the HHS-OIG. A reasonable request means a request made during hours open for business.

The CDU maintains the confidentiality of any patient information relevant to an investigation of fraud, waste, or abuse, in concert with HIPAA regulations concerning this type of investigation.

The CDU retains records obtained as the result of an investigation conducted by the CDU for a minimum period of five years or until audit questions, appealed hearings, investigations, or court cases are resolved.

Failure to supply requested information

Failure of the provider or facility to provide requested information such as medical records, invoice receipts, itemized billings by CFHP's CDU may result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and the provider may be subject to sanction or immediate payment hold.

Amendment of medical records
CFHP adheres to the Texas Administrative Code, Title 22, Part 9 Charter 165 Rule §165.1, regarding the amendment of medical records: "any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction".

Definitions:

- **Late entry**: Supplies additional information omitted from the original entry. The late entry is added as soon as possible, reflects the current date and is documented and signed by the performing provider who must have total recollection of the service provided.

- **Addendum:** Provides additional information not available at the time of the original entry. The addendum should be timely, reflect the current date, provider signature and the rational for the addition or clarification of being added to the medical record.

- **Correction:** Revisions of errors from the original entry which make clear the specific change made, the date of the change and the identity of the person making the revision. Errors must have a single line through the incorrect information allowing the original entry to remain legible. The correct information should be documented in the next line or space with the current date and time, referring back to the original entry.

For review purposes, the CDU does not accept amended documentation of existing records under any circumstances. Examples of falsifying records or amending documentation of existing records include:

- Creation of new records when records are requested
- Adding or supplementing portions of records to existing records when records are requested
- Back-dating entries
- Pre-dating entries
- Post-dating entries
- Writing over entries

Electronic Medical Record (EMR)
The purpose of the health record is to provide a basis for planning patient care and for the continuity of such care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate for date of service rendered whether in written or electronic format.

In order to protect the integrity of the health information record, ensure appropriate reimbursement, and to provide quality patient care, copy functionality within the electronic health record should be used in conjunction with applicable state and federal regulations. Noncompliant use of copy functionalities will follow the CFHP Fraud, Waste, and Abuse program. For the purpose of this Work Plan, *copy* shall be understood to include cut and paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

Documentation and coding guidelines

CFHP follows standard national guidelines pertaining to coding and documentation including but not limited to the following:

- 1997 CMS documentation guidelines for Evaluation and Management Services
- 1995 CMS documentation guidelines for Evaluation and Management Services
- CMS National Correct Coding Initiatives edits (NCCI)
- CMS Medically Unlikely Edits (MUEs)
- Physician Signature Guidelines for Medical Review Purposes MM6698, CMS Current *American Medical Association (AMA) Current Procedural Terminology (CPT)* documentation and coding guidelines as stated in the Texas Medicaid Provider Procedures Manual
- Current *International Classification of Diseases* tenth revision ICD-10 CM & ICD-10 PCS
- DRG
- Uniform Billing Editor
- Hospital Chargemaster Guide
- Novitas-Solutions

CFHP contracts with Navitus Health Solutions for pharmacy related fraud, waste, and abuse. The Navitus FWA program includes procedures and practices aimed at effective and ongoing monitoring of the control environment and programs, detection mechanisms and best practice investigation techniques when potential incidents are identified. These activities can include internal quality processes, pharmacy monitoring efforts, and vendor oversight and practices. The Navitus complete FWA plan is attached and incorporated into the overall CFHP FWA plan.