Geisinger Health Plan POLICY & PROCEDURE MANUAL	**POLICY NUMBER: 1** **SECTION**: Compliance Department/Special Investigations Unit (SIU) **SUBJECT**: Special Investigations

I. PURPOSE

Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options (hereafter collectively referred to as "the Health Plan") are dedicated to detecting, investigating, and preventing all forms of suspicious activity related to possible health insurance fraud or abuse, including any reasonable belief that insurance fraud will be, is being, or has been committed. In its work toward that goal, the Special Investigations Unit (SIU) will conduct timely investigations of suspected fraud, waste and abuse by providers, vendors, members or employees. In addition, the Health Plan will self-report findings of potential or actual fraud to the appropriate regulatory or law enforcement agency when deemed appropriate by the Associate Chief Legal Officer, Chief Compliance Officer and Director of the Special Investigations Unit (SIU). (Reporting is also referenced in section E.1.B of GHP's Fraud, Waste and Abuse Plan)

II. OBJECTIVE

To establish guidelines for the investigation process within the SIU

III. RESPONSIBILITY

Associate Chief Legal Officer, Chief Compliance Officer, Director of Special Investigations Unit and SIU Staff

IV. DEFINITIONS

A. Health Plan Required Definitions

1. Attachment – A supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – A supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – The date the policy was implemented.
4. Revised – The date of every revision to the policy, including typographical and grammatical changes.

5. Reviewed – The date documenting the annual review if the policy has no revisions necessary.

B. Policy Specific Definitions

1. Fraud – An intentional deception or misrepresentation made by a person or entity that knows or should know the deception or misrepresentation could result in some unauthorized benefit to himself/herself or some other person(s) or entities.

2. Waste – The over-utilization of services not caused by criminally negligent actions and often involves the misuse of resources. It is the needless, careless and cavalier expenditure of funds or the consumptions of property that results from deficient practice, judgments, or controls in areas of responsibility and accountability.

3. Abuse – Abuse refers to practices that while not generally considered fraudulent, and which do not involve knowing misrepresentation of facts, are inconsistent with accepted and sound medical, fiscal or business practice. These practices may directly or indirectly result in unnecessary costs to an insurance program, improper payment, or payment for services that fail to meet professional standards of care or are medically unnecessary.

4. Probe Medical Review – A review of a small percentage of provider medical records that are randomly selected from a subset of claim lines to determine if any questionable activity and/or patterns exist.

5. Full Random Sample Medical Review – A review of a larger percentage of provider medical records that are randomly selected, such that each individual claim line has the same probability of being chosen at any stage during the sampling process. These claims are reviewed to determine if any questionable activity and/or pattern exist. Since the random sample is a statistically valid representation of the entire claims universe, the medical review results can be extrapolated.

6. Extrapolation – An estimate (a value of a variable outside the known range) from values within a known range based on the assumption that the estimated value follows logically from the known values

8. Sampling – A technique that is designed to produce a subset of elements that represents the characteristics of a population or universe without having to examine the entire universe.

V. POLICY

A. **Protection Against FWA:**

The Health Plan strives to protect all lines of business from potential fraud, waste and abuse. It is the SIU's responsibility to identify cases of suspected fraud and develop them thoroughly in a timely manner. The Health Plan will take immediate action to ensure that monies are not inappropriately paid out and that any potential fraudulent payments are identified. In accordance with regulatory guidelines, the Health Plan will refer cases of potential fraud to the appropriate

regulatory agencies and/or law enforcement within 30 days. (i.e., Bureau of Program Integrity/NBI MEDIC/ OIG/OAG etc.) The SIU may also decide to submit certain Medicare referrals to the NBI MEDIC if the Unit lacks adequate resources to investigate the referral. The SIU will refer the matter to the NBI MEDIC within 30 days of the date the potential fraud or abuse is identified.

B. **Conducting a Timely and Reasonable Inquiry of Detected Offenses:**

Referrals may be received through a hotline complaint, FWA email box, member complaint, during routine monitoring or self-evaluation, an audit or by regulatory authorities. Regardless of how the noncompliance or FWA is identified, the Health Plan and SIU must initiate a reasonable inquiry as quickly as possible, but not later than 2 weeks after the date the potential noncompliance or potential FWA incident was identified. A reasonable inquiry includes a preliminary investigation of the matter by the SIU, Compliance Officer or a delegated member of his/her staff.

C. **Confidentiality:**

The SIU will maintain the confidentiality of all medical records and documents before, during, and after the Investigation and Medical Review processes, consistent with its obligations under applicable law and regulations as well as under applicable Health Plan policies and procedures. Similarly, any of the Health Plans subcontractor(s) that perform Medical Review, store Medical Review documents, and/or transport Medical Review documents, are responsible for ensuring that the confidentiality of Medical Review documents are secured. This responsibility applies to all contact with these documents by all parties and entities, however derived.

VI. PROCEDURE

A. SIU Responsibilities

The Health Plan's SIU recognizes the importance of detecting, preventing, investigating, and reporting fraud, waste, and abuse for all lines of business. It is the Health Plan's policy to investigate any action by providers, vendors, members, or employees that impact the integrity of the Medicare, Medicaid, CHIP, Marketplace, Commercial, or Federal Employee Health Benefits Program's (FEHBP). The SIU staff responsibilities include, but are not limited to:

- Conduct investigations of suspected fraud or suspicious activity;
- Evaluate reports of FWA and suspicious activity to identify or substantiate FWA allegations;
- Conduct proactive data mining to identify questionable billing practices by providers as well as review member utilization for questionable trends.
- Identify and establish internal controls to prevent or ensure early detection of fraud waste and/or abuse;
- Collect evidence of potential fraud for possible referral to law enforcement or regulatory authorities;
- Pursue civil recovery against those who have submitted false claims;

- Serve as the liaison for dissemination of information to/from state fraud bureaus and other state/federal law enforcement agencies;
- Work with law enforcement, state fraud and regulatory bureaus, and industry associations involved in anti-fraud initiatives; and
- Provide anti-fraud training to the Health Plan staff.

B. Investigation/Detection Techniques

The SIU may utilize a variety of techniques and tools to assist in the prevention, detection and investigation of potential fraud and abuse activities. These may include:

- Utilization of a predictive analytic fraud detection system that pinpoints patterns of suspicious behavior across all health care claims submitted to the Health Plan for payment;
- Review provider utilization reports (provider profiles) based on provider type or subtype to detect over or under utilization of a billing code, codes or services;
- Monitor claims edits used to prevent duplicate payments, improper utilization and deter potential fraud before payment;
- Encourage reporting by employees, vendors, members and providers to the SIU;
- Review applicable industry information, from the annual OIG Work Plan, OIG, CMS, AHIP, National Healthcare Anti-Fraud Association (NHCAA) and other informational resources as applicable
- Reference to and compliance with applicable state and federal regulations regarding preventing, detecting, and investigating suspicious activities and potential fraud; and
- Correspondence and communication with delegated entities and subcontractors.

C. **Investigation/Referral Tracking**

The SIU maintains a case log for each referral and active/closed investigations. The SIU documentation includes, but is not limited to:

- Date referral was received and summary of referral;
- Details of individual reporting the incident (unless reported anonymously);
- Details of suspected member, provider or practitioner, if applicable;
- Description/statement of the incident;
- Full investigation history and description;
- Supporting documentation related to the referral/investigation;
- Dollars at risk;
- Risk Assessment Score;
- Probe Medical Review/Full Random Sample documentation including sample size, random number generation and extrapolation worksheets;
- Overpayment details (if applicable)
- Resolution description;
- Date incident reported to law enforcement/regulatory agency (if applicable); and

- Provider education (if applicable).

D. **Initiation of Reasonable Inquiry**

1. Once the SIU receives a referral of potential FWA, the SIU or designated staff will initiate a reasonable inquiry immediately, but no later than two weeks from the date that the potential misconduct is identified. The SIU staff will reference Attachment # 1 (FWA Referral & Triage Process Map) when triaging the referral. Initial inquiry activities may include, but are not limited to:

- The SIU staff will review the FWA Case Log to determine if existing or previous investigations exist. If a previous investigation is identified, the SIU staff will determine the outcome of the investigation and whether the new allegation is the same or related to the previous investigation. If applicable, a copy of the previous investigation report will be added to the new referral/investigation file;
- If applicable, the SIU staff will contact the individual submitting the referral to acknowledge that the SIU has received the referral and that the referral will be investigated fully;
- All details of the referral will be entered into the FWA Case Log (STARSCommander) If the referral involves a provider or practitioner, the SIU staff may obtain current license status information (i.e., NPI, Medical/Pharmacy License etc.);
- If applicable, the SIU staff may request any previous provider education, contract detail, visitation or complaints from Provider Network Management (PNM) or Medical Management (MM);
- The SIU staff may review CSI for customer care activity including recent calls, issues and/or complaints. They may also research CSI to verify claims information;
- The SIU staff may conduct preliminary data analysis utilizing data mining tools. If more in in-depth reporting is required, the SIU staff may submit a data request to the Actuarial Informatics Department.

2. If the SIU determines that the initial inquiry provides enough evidence to warrant opening an investigation and it has available time, resources, and experience to investigate the referral, the SIU will initiate an investigation to determine if potential fraud, waste and/or abuse has occurred.

3. Once the SIU staff makes the determination whether to open an investigation or close the referral, they will proceed to present the initial findings and next steps to the FWA Triage Team. The FWA Triage Team is comprised of leadership staff from internal departments that may include Legal, Compliance, Provider Network Management, Payment Integrity, and Medical Management. The SIU must conduct all investigations of potential misconduct within a reasonable time-period after the potentially fraudulent activity is discovered.

E. Investigation/ Medical Review Process

1. The SIU staff will reference Attachment # 2 (FWA Investigation Process Map) while conducting all investigations.

2. The SIU staff will complete the FWA Risk Assessment document to determine the total risk score. The FWA Risk Score has the following priority levels:

(0-8) Low Risk/Low Priority

(9-15) Moderate Risk/Moderate Priority

(16-25) High Risk/High Priority

The FWA Risk Score will be used by the SIU staff when developing an investigation plan. The score will also help the SIU staff to manage their caseload by placing greater priority on cases with a higher risk score.

3. When initializing an investigation, the SIU staff will develop an investigative plan for each investigation. An investigation plan will keep the investigation on track and organized as well as maintain focus. It also ensures an efficient use of resources and prevents duplicate efforts. The investigation plan may include the following steps and should always be accessible in the investigation file:

- Document allegation
- Analyze source
- Assign risk score
- Document rationale and evidence for opening investigation
- Develop action items/tasks for completion and projected time frames
- Evaluate possible information sources or resources to consult (e.g., clinical expertise, data requests, medical record reviews
- Determine expected completion date

  NOTE: Each step of the investigation will be documented on the investigation plan document.

4. During the investigation, the SIU staff may need to proceed with either a Probe Medical Review or a Statistically Valid Random Sample (SVRS). This typically consists of an on-site or desk audit. Please refer to the *Probe and Random Sample Medical Review Process Policy and Procedure (Policy #1, Legal Services/SIU)* for further clarification on this process. Note: When proceeding with a medical record request, the SIU staff will meet with clinical staff to identify medical review criteria and resources.

5. If the SIU staff needs to make a major change to the investigation plan or has finalized the investigation, they will review the changes and/or findings with all applicable internal departments (e.g. Legal/Compliance/PNM/Finance), FWA Triage Team, FWA Committee and Medical Director as necessary, to make the decision on the next steps of the investigation. The next step may include: Closing the case, educating the member/provider/employee, pursuing financial loss, referring the case to the appropriate

regulatory agency or law enforcement.

6. At any point in the investigation process, the SIU may elect to suspend payments to a member or provider suspected of committing FWA. Payments will be pended until the investigation is complete. The SIU will send a notification to the provider that all payments are suspended within 5 calendar days of taking such action unless requested in writing by the Bureau of Program Integrity, OIG, OAG etc. Before suspending payments, the SIU staff obtain approval from all applicable internal departments (e.g. Legal/Compliance/PNM/Finance), FWA Triage Team, FWA Committee and Medical Director as necessary.

F. Summary and Final Reports

1. If an overpayment or inappropriate payments are identified during the investigation, every effort will be made to recover the full overpayment. When pursuing restitution for financial loss, the case will be reviewed by applicable internal departments (e.g., Legal/Compliance/PNM/Finance etc.) to determine the likelihood and method of recovery. The SIU will provide an Audit Summary Report to the member/provider that includes a summary of the findings and the total overpayment identified. The member/provider will have an opportunity to dispute the findings.

2. The member/provider will be provided thirty (30) days from the date of the Audit Summary Report to respond to all discrepancies and to submit additional documentation for review as determined by the SIU. The member/provider must submit a letter of dispute accompanied by all documentation related to the discrepancy in question, any relevant policies as previously described, and any other supporting information to the Health Plan's SIU. The SIU will review the dispute, research the issue(s) and consult Health Plan clinicians, FWA Triage Team, FWA Committee and other subject matter experts as necessary. The Health Plan will make a good faith effort to review the dispute and notify the provider/member in writing of the final determination within thirty (30) days of receipt of the dispute. The Health Plan reserves the right to extend the review period if necessary to complete a full and final review. If the review period is extended, the SIU will notify the member/provider in writing of the extension. At the conclusion of the thirty (30) day response period, the member/provider will receive a Final Audit Summary Report.

E. Recovery and Reporting:

1. Any overpayments and/or underpayments identified at the conclusion of the audit will be adjusted or retracted as indicated by the Final Audit Summary Report. Audit related retractions and/or claim adjustments will be identified on future remittance advices.

2. If after review or any time during a review it is determined that a credible allegation of fraud exists, the Health Plan will refer the case to the appropriate regulatory and/or law enforcement agency within 30 days of such determination. Examples of agencies to whom the Health Plan may refer cases to include, but are not limited to:

i. The Office of Inspector General (OIG)

ii. The Centers for Medicare and Medicaid Services (CMS)
iii. Department of Public Welfare – Bureau of Program Integrity (DPW/BPI)
iv. Federal Bureau of Investigation (FBI)
v. National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC)

Approved:

Signed: Paul O. Peoples

Title: Sr. Director, Special Investigations Unit

Date: 12/1/2016

This policy will be revised as necessary and reviewed no less than annually.

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