

Medica's position on and investigation of fraud and abuse, Medica's Special Investigations Unit (SIU), and financial and health record-keeping requirements.

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Chapter 20: Fraud and Abuse

Section A: Overview

Subsection 1: Anti-fraud Plan and Medica's Special Investigations Unit (SIU)

Medica believes that it is in the best interest of its participating providers, members and the community to prevent fraud and abuse, which have a significant impact on health care and health insurance costs. Fraud and abuse deterrence is not only good business practice by Medica and its providers, but also contributes to the efficiency and quality of the health care system. Medica can thus continue to deliver appropriate services to its members and providers.

Medica closely examines allegations of fraud and abuse, investigates the evidence and seeks appropriate remedies, which **may include civil or criminal action**.

Legal requirement

Minnesota Law requires Medica to:

- File an annual anti-fraud plan with the Minnesota Department of Human Services (MDHS).
- Have the plan on file at the Minnesota Department of Commerce.
- Refer suspected fraud to law enforcement.

Medica's Special Investigations Unit (SIU)

In 1998, as part of its anti-fraud plan, Medica developed the Special Investigations Unit (SIU) to investigate allegations of fraud and abuse committed against Medica. The SIU's mission is to prevent, identify, investigate, report and, when appropriate, recover money from health care fraud and abuse. These actions help ensure that member premium dollars are spent for legitimate health care purposes. The SIU is authorized to conduct post-payment reviews to ensure compliance with Medica requirements. To accomplish this, the SIU monitors use of health services by members and the delivery of health services by Medica's participating providers.

Impact on credentialing

Acts of fraud and abuse can prevent the credentialing of individuals or organizations to participate with Medica.

Reporting fraud or abuse

To report suspected fraud or abuse committed against Medica, call Medica's Special Investigations Unit at 952-992-8478 or 1-800-458-5512, provider option 1, then option 8, ext. 2-8478, during business hours. At other times, please call Medica's Fraud Hotline at 952-992-2237 or 1-866-821-1331.

***You can access
Minnesota statutes
and rules referred to
in this text at
[www.leg.state.mn.us/
leg/statutes.htm](http://www.leg.state.mn.us/leg/statutes.htm).
The Code of Federal
Regulations cited here
is available at
[www.access.gpo.gov/
nara/cfr/index.html](http://www.access.gpo.gov/nara/cfr/index.html).***

Chapter 20: Fraud and Abuse

Section A: Overview

Subsection 2: What Constitutes Fraud and Abuse

Participating providers should notify the SIU of any situations where **provider billing fraud may have occurred**, or where **members have engaged in fraudulent or abusive activity**. Examples of the former include billing for services not rendered, or misrepresentation of claim data (such as upcoding or unbundling). Member abuse includes falsification of enrollment information, altering or fabricating claims, or prescription drug forgery. Following are more specific definitions and examples.

Abuse

In the case of a health care provider, abuse is a pattern of practice that is inconsistent with sound fiscal, business or health service practices, and that results in unnecessary costs to Medica or in reimbursement for services not medically necessary, or that fails to meet professionally recognized standards for health services.

The following practices by a provider may be deemed to be abuse:

- Repeatedly submitting claims from which required information is missing or incorrect.
- Repeatedly submitting claims using procedure codes that overstate the level or amount of health service provided.
- Repeatedly submitting claims for health services that are not reimbursable by Medica.
- Repeatedly submitting claims for the same health service provided to the same member.
- Repeatedly submitting claims that do not comply with the requirements to be a covered service.
- Repeatedly submitting claims for services not medically necessary.
- Failing to maintain health records as required by federal and state law.
- Failing to use generally accepted accounting principles or other accounting methods that relate entries on the member's health record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule.
- Failing to disclose or make available to Medica a member's health record or a provider's financial records as defined in the provider contract.
- Repeatedly failing to report duplicate payments from third-party payers for covered services provided to Medica members that were billed to Medica.
- Failing to keep financial records for the services provided to Medica members as required by federal and state law.
- Repeatedly submitting or causing submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification or a second medical opinion.
- Submitting a false or fraudulent application for provider status.

- Soliciting, charging or receiving payments from Medica members, in violation of the provider agreement with Medica.
- Payment of health plan funds to a second provider whom the primary provider knew was suspended or barred from participating in federal health care programs.
- Repeatedly billing Medica for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability.
- Repeatedly failing to comply with the requirements of the contract entered into with Medica.

Fraud

Fraud consists of any acts that constitute a crime against Medica or other health care programs, or attempts or conspiracies to commit those crimes, including the following:

- Theft, perjury, forgery and aggravated forgery.
- Making a false statement, claim or representation to Medica or other health care programs when the person knows or should reasonably know the statement, claim or representation is false.
- Receiving remuneration in return for the provision of health care services in violation of the Stark Law (42 U.S.C., sect. 1395nn) or the Anti-kickback Statute (42 U.S.C., sect. 1320a-7b(b)).

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Section A: Overview

Subsection 3: Investigative Process

Medica's SIU conducts **routine audits of participating providers** to monitor compliance with contractual agreements and administrative protocols.

Information is collected from sources such as:

- Government agencies.
- Third-party payers, including Medicare and Medicaid.
- Professional review organizations.
- Members and their responsible relatives.
- Providers and people employed by or under a provider contract.
- Professional associations and boards of providers and their peers.

An SIU investigation may include:

- Examination of health service and financial records.
- Examination of equipment, materials, prescribed drugs or other items used in a member's health service.
- Examination of prescriptions written for members.
- Interviews of anyone with information pertinent to the allegation of fraud or abuse.
- Verification of the professional credentials of a provider, the provider's employees and entities under contract with the provider.
- Determination of whether the health care provided was medically necessary.
- Suspension of claims payment until the investigation is complete.

Following completion of the investigation, the SIU will determine whether:

- The provider is in compliance with the requirements of the contract and administrative protocols.
- The evidence of fraud, theft or abuse supports administrative, civil or criminal action.

After completing the determination, the SIU will take one or more of the following actions:

- Close the investigation when no further action is warranted.
- Impose administrative sanctions.
- Seek monetary recovery.
- Refer the investigation to the appropriate state regulatory agency.
- Refer the investigation to the appropriate local law enforcement officials for review pursuant to Minnesota law.

Administrative sanctions that may be imposed are:

- Placing restrictions on the provider.
- Referral to the appropriate state licensing board.
- Suspension or termination of the provider contract.
- Suspension or termination of the participation of any person or corporation with whom the provider has any ownership or controlling interest.
- Requiring a contract that stipulates specific conditions of participation.
- Review of the provider's claims before payment.
- Suspending payments to the provider.

Medica has the **authority to simultaneously seek monetary recovery and to administer sanctions.**

Medica will **notify provider in writing** of any intent to recover money or impose sanctions.

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Section B: Record-keeping Requirements

Subsection 1: Medica's Access to Records

Medica's Special Investigations Unit (SIU) has the right to access records pursuant to the provider contract and the member's consent signed in accordance with Minn. Statute 144.335.

During the term of an agreement with Medica and for six years following its termination, the provider shall give Medica and its authorized agents—including the SIU—access to all information and records related to health services provided according to the agreement, to the extent permitted by law and without further authorization by any member.

The provider shall submit copies of records requested by Medica **within 14 days** from the date of such request, or sooner if necessary to comply with laws related to the resolution of member complaints or to cooperate with an investigation by Medica's SIU. If the provider fails to comply, Medica has the right to withhold reimbursement for health services until the provider fully complies and Medica and/or its authorized agents have reviewed the information and records.

Medica shall reimburse the provider for records given to Medica as set forth in this manual in Chapter 14, section B, subsection 2, page 4 of 4.

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Section B: Record-keeping Requirements

Subsection 2: Health Records

Health records are any electronically stored data, and written or diagrammed documentation of the nature, extent and medical necessity of a health service provided to a Medica member by a provider and billed to Medica.

Health records must be created and maintained as a condition of payment by Medica. Each occurrence of a health service must be completely, promptly, accurately and legibly documented in the member's health record. The information must be maintained in an orderly fashion and easily accessible. Medica funds that are paid for services not documented in the health record are subject to monetary recovery.

Health records must contain the following information, when applicable. Any additional record obligations specific to providers of a particular service are detailed in the provider contract and elsewhere in this manual.

- The member's name must be on each page of the record.
- Each entry must contain:
 - The date on which the entry is made.
 - The date or dates on which the health service is provided.
 - The length of time spent with the member if the amount paid for the service depends on the time spent.
 - The signature and the title of the person from whom the member received the service.
- The record must state:
 - The initial assessment and subsequent reassessments of the member's needs.
 - The current plan of treatment.
 - Identification data and consent or authorization forms.
 - Pertinent past and present medical history.
 - A report of pertinent physical examinations, if any.
 - Progress notes or other documentation that reflect reaction to treatment, tests or injury, or the need to change the established treatment plan.
 - Upon discharge, a discharge summary including status relative to goal achievement, prognosis and future treatment considerations.

Please refer to Chapter 14, Section B, subsection 2 in this manual for more information on Medica's requirements related to medical record keeping.

Protection of clinical record information

The provider must:

- Safeguard record information against loss, destruction or unauthorized use.
- Have procedures that govern the use and removal of records and the conditions for release of information.
- Obtain a member's written consent before releasing information not required to be released by law.

Record retention and preservation

The provider must retain clinical record information for five years after member discharge and must make provision for the maintenance of such records in the event that the provider is no longer able to treat patients.

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Subsection 3: Financial Records

Financial records—including written and electronically stored data—of a provider who receives payment for a member's services from Medica must contain:

- Payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared by or for the provider.
- Contracts for services or supplies relating to the provider's costs and billings to Medica for members' health services.
- Evidence of the provider's charges to Medica members, consistent with the Minnesota Government Data Practices Act.
- Evidence of claims for reimbursement, payments, settlements or denials resulting from claims submitted to programs, i.e., Medica and other third-party payers as well as Medicare and Medicaid.
- The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable.
- Billing transmittal forms.
- Records showing all persons, corporations, partnerships and entities with an ownership or controlling interest in the provider—as defined in the Code of Federal Regulations, title 42, part 455, sections 101 and 102.
- Employee records for those persons currently, or within the previous five years, employed by the provider that under the Minnesota Government Data Practices Act would be considered public data for a public employee, e.g., employee name, salary, qualifications, position description, job title and dates of employment. Employee records should include the current home address of the employee or the last known address of any former employee.

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Section C: Policy on Reporting of Suspected False Claims

Scope:

This policy applies to all Medica contractors, agents and temporary employees.

Purpose:

To communicate Medica's written policies regarding the Deficit Reduction Act of 2005 (for more information see 42 U.S.C. §1396a(a)(68)) and Medica's expectations regarding contractors, agents and temporary employees' reporting of reasonably suspected violations of laws and regulations applicable to Medica, to the extent the contractor, agent or temporary transacts Medicaid business on behalf of Medica.

Policy Statement:

Medica takes health care fraud and abuse very seriously. It is our policy to provide information to all contractors, agents and temporary employees about the federal and Minnesota laws related to false claims, remedies available under these provisions and protections under these laws.

No contractor, agent or temporary employee will suffer any penalty or retribution for reporting, in good faith, any suspected misconduct or noncompliance.

Practice/Procedure:

This policy must be made available to Medica contractors, agents, employees of such entities and Medica temporary employees.

Any good faith belief of any suspected or known violation of the laws and regulations that govern Medica's business may be reported by calling:

Medica's Special Investigations Unit at 952-992-8478 or 1-800-458-5512, provider option 1, then option 8, ext. 2-8478, during business hours. At other times, please call Medica's fraud Hotline. For English and Spanish call 952-992-2237 or 1-866-821-1331. For Russian 952-992-3893; for Somali 952-992-3214.

Medica contractors, agents and temporary employees may also visit www.medica.com and click on the "Fraud and Abuse" link to download and print the Investigative Inquiry Form, which can be faxed to the SIU Department at 952-992-3117.

BACKGROUND:

As a provider of services that involve state and federal public dollars, Medica is subject to certain laws designed to curtail fraud, waste and abuse of these dollars. (Note: the citations below refer to the United States Code ("U.S.C."), the Code of Federal Regulations ("C.F.R."), Minnesota Statutes ("Minn. Stat.") and Minnesota Rules ("Minn. Rule")).

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FEDERAL LAWS

Federal laws regarding fraud and abuse include, but are not limited to:

- The Federal False Claims Act [42 U.S.C. §1396a(a)]
- The Program Fraud Civil Remedies Act [31 U.S.C. §§ 3801-3812]
- Deficit Reduction Act of 2005 [Pub. Law 109-171, §6032]
- Medicaid Integrity Program [42 C.F.R. §455]
- Federal Anti-kickback Statute [42 U.S.C. §1320a-7b(b)]
- Civil Monetary Penalties Law [42 U.S.C. §1320a-7a]
- Health Care Fraud [18 U.S.C. §1374]
- False Statement Re Health Care [18 U.S.C. §1035]

The False Claims Act (“FCA”) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. Anyone who knowingly submits or causes someone else to submit a false or misleading claim for government funds is liable to the federal government for civil damages. The law is set forth at 31 U.S.C. §§3729-3733. A claim is broadly defined to mean any request for money or property made to an entity where a portion of the requested money or property would come from the US Government.

In sum, the FCA prohibits:

1. Knowingly presenting, or causing to be presented to the Government a false claim for payment;
2. Knowingly making, using, or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
3. Conspiring to defraud the Government by getting a false claim allowed or paid;
4. Falsely certifying the type or amount of property to be used by the Government;
5. Making or delivering a document certifying receipt of property for Government use without completely knowing that the information on the receipt is true;
6. Knowingly buying or receiving Government property from an unauthorized officer of the Government; and
7. Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

The terms “knowing” or “knowingly” are defined as when a person, who with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information.

Violations of the Federal FCA may lead to civil penalties of \$5,500 to \$11,000. Fines may also include treble damages up to three times the amount of the original penalty and the violator can be excluded from participating in the Medicare and Medicaid programs. No proof of specific intent to defraud is required to establish liability under the FCA.

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Under the FCA, at 31 U.S.C. §3730, a whistleblower may bring a civil action on behalf of the government for a violation of the FCA (this type of action is called a “qui tam” lawsuit). After filing with Department of Justice, the government can pursue the claim on its own, or decline to intervene and allow the whistleblower to continue. If the whistleblower’s case goes forward, no one else can bring a separate action later. The whistleblower also has protection from possible retaliation by his or her employer or fellow employees. Any person who is harassed or discriminated against because of his or her involvement in a qui tam action has the right to be made “whole.” The whistleblower’s damages may include reinstatement of their job position, two times back pay, plus interest, and compensation for any special damages including reasonable litigation and attorneys’ fees.

The Program Fraud Civil Remedies Act of 1986, set forth at 31 U.S.C. §§ 3801-3812, provides administrative remedies, including civil penalties and assessments, that may be imposed against people making false claims and statements to federal agencies. The Act provides that any person who makes, presents or submits a claim to an “authority” (an executive department or an establishment, a military department or the U.S. Postal Service) that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil penalty of up to \$5000 per false claim or statement and up to twice the amount claimed in lieu of damages. No proof of specific intent to defraud is required to establish liability under this chapter.

Section 6034 of the Deficit Reduction Act (“DRA”) established the Medicaid Integrity Program (“MIP”) which increased the Center for Medicare and Medicaid Services’ (“CMS”) resources to prevent and respond to Medicaid fraud and abuse.

The Anti-Kickback Statute: The Anti-Kickback Statute is found at 42 U.S.C. §1320a-7b(b). In general, the Anti-Kickback Statute prohibits:

- knowing and willful solicitations or receipt of remunerations in return for referring an individual or purchasing a type of service or
- knowing and willful offer or payment of remuneration to refer an individual or for purchasing a type of service for which a Federal health care program may pay. (But note that certain transactions that would be prohibited are allowed under the “Safe Harbors.”) The prohibition applies to both parties in the arrangement. Both civil and criminal penalties may be applied. Criminal penalties include up to five years in prison plus \$25,000 in fines. Civil penalties include up to \$50,000 in fines and three times the lost dollar amount.

Federal False Statements Relating to Healthcare Matters

In any matter involving a “health care benefit program,” 18 U.S.C. §1035 states that whoever knowingly and willfully:

- falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
- makes a materially false, fictitious, or fraudulent statement or representation, or makes or uses any materially false writing or document, knowing it contains a materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, may be fined and imprisoned for up to five years.

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Federal Healthcare Fraud

As part of HIPAA, the U.S. Criminal Code was amended to include a prohibition against committing any scheme to defraud a federal healthcare program or making any false or fraudulent representations. It is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any healthcare benefit program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any health care benefit program. The Healthcare Fraud offenses created by HIPAA are found at 18 U.S.C. §1347. Penalties include a fine and imprisonment up to ten years.

MINNESOTA LAW

Minnesota laws regarding fraud and abuse include, but are not limited to:

- Surveillance and Utilization Review Program – MN Dept. of Human Services [Minn. Rule 9505.2200]
- Theft of Medical Assistance funds [Minn. Stat. 609.466]
- State Attorney General investigative powers [Minn. Stat. 8.31]
- Whistleblower protections [Minn. Stat. §181.932]

The Surveillance and Utilization Review Program is managed by the Minnesota Department of Human Services, as set forth at Minn. Rule 9505.2200. The Program seeks to identify fraud, theft and abuse in the administration of the Program, and investigate vendors or recipients of medical assistance to monitor compliance with program requirements, as authorized under the federal Medicaid Integrity Program at 42 C.F.R. §455.

Theft of Medical Assistance Funds is addressed by Minn. Stat. §609.466, which provides that any person, who, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds to a state agency, which is false in any way, is guilty of an attempt to commit theft of public fund.

The Attorney General, under Minnesota Statutes section 8.31, is authorized to investigate violations of the law of this state respecting unfair, discriminatory, and other unlawful practices in business, commerce, or trade.

Temporary employee, contractor and agent protections under Minn. Stat. §181.932. The statute states that an employer may not discharge, discipline, threaten, otherwise discriminate against, or penalize an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee, in good faith, reports a violation or suspected violation of any federal or state law or rule to an employer or to any governmental body or law enforcement official.