HIGHMARK WHOLECARE

Fraud, Waste and Abuse Definitions:

Providers are responsible to know the following fraud, waste, and abuse (FWA) definitions as applicable to Medicaid and Medicare:

- **Fraud:** An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a health plan, a subcontractor, a provider, a state employee, or a member among others.

- **Waste:** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs.
    - Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- **Abuse:** Any practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid/Medicare Programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, Medicaid contracts, Medicare manuals, and the requirements of state or federal regulations) for health care in a managed care setting.
    - Abuse can be committed by the health plan, subcontractor, provider, state employee, or a member, among others. Abuse also includes member practices that result in unnecessary cost to the Medicaid/Medicare Programs, the health plan, a subcontractor, or provider.

- **Compliance Program:** To ensure compliance with FWA requirements of Medicaid contracts and Medicare manuals Highmark Wholecare and providers will have:
    - Written policies, procedures, and standards of conduct readily available for all employees which outlines our committment to a FWA program,
    - Effective training and education related to FWA for all employees, first tier and downstream entities, or subcontractors,
    - Mechanisms to report compliance issues or FWA,
    - Enforcement standards through publicized disciplinary guidelines,

- Provisions for internal monitoring and auditing, and
- Provisions to promptly take action to detected offenses and develop corrective action initiatives.

- **Fraud, Waste and Abuse Team**: A multi-faceted team within Highmark Wholecare that is involved in detecting and investigating FWA. In addition, the team works to ensure that claims are paid correctly by both pre-pay and post-pay auditing methods and in accordance to recipient benefits and provider contracts.

Fraud, Waste and Abuse Recovery Requirements:

We have fraud, waste and abuse functions that are responsible for ensuring claims payment accuracy and to detect and prevent FWA which include:

- Pre-payment claims edits
- Retrospective claims reviews
- Provider education
- FWA investigations and audits

Our company's fraud, waste and abuse functions rely on reimbursement policies, medical record standards, and coding requirements that are outlined in the following: Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), National Correct Coding Initiative (NCCI), National Committee for Quality Assurance (NCQA), and state Medicaid regulations. Additionally, all claims should be coded and documented in accordance with the HIPAA Transactions and Code Sets which includes: ICD-9-CM, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, HCPCS Codes, CPT Code, and Other HIPAA code sets.

We will conduct pre- payment and retrospective reviews of claims and medical records to ensure claims accuracy and record standards. We will recover claims payments that are contrary to national and industry standards. We will conduct progressive reviews, such that, providers may be requested to submit additional samples or documentation during the reviews. If any of the payment integrity efforts identify overpayments, the following activities will occur:

- We will comply with all federal and state guidelines to identify overpayments,

- We will pursue recoveries of overpayment through claims adjustments with recoveries by claims offsets or provider checks within 60 days,
- We will refer suspected FWA to appropriate agencies, such as Medicaid oversight and CMS Medics; and
- We may recommend corrective actions that may include pre-payment review, payment suspension, and potential termination from Highmark Wholecare's provider network.

Highmark Wholecare may pursue overpayments for the following reasons, but is not limited to:

NCCI Procedure to Procedure (PTP) edits
NCCI Medically Unlikely (MUE) edits
NCCI Add-On Code edits
Retrospective coordination of benefits
Retrospective termed member eligibility
Retrospective rate adjustments
Incorrect fee schedule applied to claim
Provider excluded
Provider license terminated or expired
Provider does not meet the requirements to render services
Different rendering provider
No authorization or invalid authorization
Inaccurate claim information
Duplicate claims
Non-covered service
Outpatient services while member was inpatient
Overlapping services
Patient different than member
Per diem services billed as separate or duplicate charges
Services provided outside of practice standards
Group size exceeds limitations
No services provided including no-shows and cancellations
Missing records
Missing physician orders

Missing medication records
Missing laboratory results
Invalid code or modifier
Invalid code combinations
Diagnosis codes that do not support the diagnosis or procedure
Add – on codes reported without a primary procedure code
Clinical documentation issues
Claims documentation issues
Insufficient documentation
Potential fraudulent activities
Excessive services
Altered/forged records

Fraud, Waste and Abuse Medical Record Standards:

Highmark Wholecare requires providers to have medical records that comply with CMS AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations, and Medicare manuals as well as other applicable professional associations and advisory agencies. Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under Federal and State regulations, publications, and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals, and all regulations.
- Providers are responsible for having compliance programs that prevent and detect FWA and report and return overpayments within 60 days of identification.
- Providers must have member records that include all Medicaid and/or Medicare requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.

- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.
- Each medical record should be individualized and unique and should include a patient identifier on every page. (No clone or copying and pasting of medical records)

Consent to Treatment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by clinician
	Lists the types of services and/or treatments
	Includes the benefits and any potential risks
	Includes alternative services and/or treatments
	Must be easy to read and legible

Release of Information for Payment	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Lists the types of services and/or treatments
	Must be easy to read and legible

Privacy Practices	Valid for dates of service
	Identifies the patient
	Signed and dated by patient
	Signed, dated, and credentialed by author/clinician
	Must be easy to read and legible

Medical Information	Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work
	Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
	Allergies and adverse reactions

	Significant illnesses and medical conditions
	Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals, and periodic updates
	High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social and emotional risks, etc.)
	Laboratory and other studies ordered
	Continuity of care is documented
	Immunizations and dates
	Must be easy to read and legible

Treatment Plan	Valid for dates of service
	Identifies the patient
	Signed and dated by clinician (witness or author's identification)
	Documents that member or guardian reviewed or participated with the development of the treatment plan
	Addresses the chief complaint and clinical finding with a plan of care consistent with standards of care and clinical practice
	Identifies the diagnosis
	Identifies interventions and goals of treatments
	Documents necessity for treatment
	Reviews are completed timely as applicable
	Must be easy to read and legible

Progress / Clinical Entry Note	Dates of Service
	Identifies the patient
	Signed, dated, and credentialed by author/clinician
	Start and stop times for time-based services
	Units of service
	Place of service
	Note is missing narrative/description of services
	Note does not identify the treatment goals and objectives
	Note does not list symptoms and behaviors
	Note does not identify follow-up or next steps in treatment

	Corresponding encounter or timesheets as applicable
	Must be easy to read and legible

Medication List	Medication prescribed
	Signed and dated by clinician
	Lists dosages, dates, and refills
	References the side effect and symptoms
	Must be easy to read and legible