

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 1 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

I. **SCOPE:**

This document describes the internal Pro Care Health Plan, Inc. (Pro Care) processes to prevent, detect, and reduce the occurrence of fraud and abuse in order to comply with state and federal fraud and abuse Laws.

II. **POLICY:**

Pro Care strives to comply with applicable federal and state fraud and abuse Laws by taking appropriate measures that are reasonably capable of detecting, preventing and/or reducing the occurrence of fraud and abuse by Pro Care Personnel and other agents, contracted and non-contracted health care providers ("Providers"), other Contractors, and Members.

III. **DEFINITIONS:**

A. **Fraud** is defined as the intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable state and federal Laws. Examples of fraud include, but are not limited to:

1. Billing for services not provided;
2. Billing for services in a manner other than as actually provided;
3. Billing for services which were not medically necessary or provided by an unqualified person;
4. Services provided are accompanied by an illegal inducement to utilize or refrain from utilizing a service (kickback); and
5. Underutilization and denial of necessary medical care;
6. Member using expired ID card;
7. Someone other than a Member using an ID card;
8. Member giving false information to get medical or pharmacy services.

B. **Abuse** is defined as Personnel or Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary costs to the Medicaid program.

IV. **PROCEDURE:**

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 2 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

Pro Care will adopt and implement a number of measures to prevent, detect, and/or reduce the occurrence of fraud and abuse:

- A. Pro Care has a corporate Compliance Program that includes the following:
1. Written policies and procedures and standards of conduct that articulate Pro Care's commitments to comply with all applicable local, state and federal Laws and other legal obligations;
 2. The designation of a corporate compliance officer ("CCO") and a corporate compliance committee ("CCC") that are accountable to the Board of Directors;
 3. Effective training and education for Pro Care Personnel (including the CCO and CCC) and, as appropriate, contracted Providers and other Contractors;
 4. Effective lines of communication between the CCO and Pro Care's Personnel;
 5. Provision for internal monitoring and auditing of areas that are at risk for potential fraud and abuse;
 6. Prompt investigation of reports or monitoring findings regarding suspected fraud or abuse;
 7. Development of corrective action initiatives relating to the Medicaid program contract and other sponsor contracts;
 8. Enforcement of compliance standards of conduct and compliance P&Ps through written disciplinary guidelines; and
 9. Documentation of Pro Care's compliance activities.
- B. Pro Care Personnel have the obligation of reporting suspicion or knowledge of fraud or abuse to the CCO, their supervisors, or other person of responsibility and authority within Pro Care. At the request of the reporting person, Pro Care will provide such anonymity to the reporting person as is possible under the circumstances in the judgment of Pro Care, consistent with applicable Laws and its obligations to investigate the

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 3 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

concerns and take necessary corrective action. There will be no retaliation or retribution against Personnel for good faith reporting of suspected fraud or abuse.

- C. Members are instructed in their Member Handbook on how to report fraud and abuse. Contracted Providers are instructed in the Provider Manual on how to report fraud and abuse.
- D. Providers and Members may report suspected fraud or abuse to Pro Care's CCO, Chief Executive Officer or other person as directed in the Provider Manual. Reports may be made orally or in writing. At the request of the reporting person, Pro Care will provide such anonymity to the reporting person as is possible under the circumstances in the judgment of Pro Care, consistent with applicable Laws and its obligations to investigate the concerns and take necessary corrective action. There will be no retaliation or retribution against a Provider or Member for good faith reporting of suspected fraud or abuse.
- E. Providers and Members also may report suspected fraud or abuse to the Michigan Department of Community Health ("DCH") Program Investigation Section or the State Attorney General ("AG") Health Care Fraud Division. The individual may call the DCH Program Investigation Section toll-free at 866-428-0005 or send a memo or letter to: Program Investigation Section, Capitol Commons Center Building, 400 S. Pine, 6th Floor, Lansing, MI 48909. The individual may contact the AG Health Care Fraud Division, at P.O. Box 30218 Lansing, Michigan 48909 or by calling toll-free at 1-800-24-ABUSE.
- F. Pro Care's credentialing and recredentialing procedures for contracted Providers include inquiries regarding and review of fraud and abuse sanctions under state and federal programs and criminal history.
- G. Pro Care screens Personnel and Contractors with respect to fraud and abuse sanctions under state and federal programs and criminal history.
- H. Pro Care provides educational materials to Members that include information regarding the detection and reporting of suspected fraud and abuse.

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 4 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

- I. Pro Care has committees (such as Credentialing, Member Services, Finance, Pharmacy and Therapeutics, Quality Management, and Utilization Review) which review either clinical information or financial information or submissions.
- J. Pro Care's Provider contracts and other Contractor contracts include provisions that require Providers and other Contractors to comply with Pro Care and state and federal:
 1. Reporting requirements, including reports of exclusions or other sanctions under state and federal fraud and abuse Laws;
 2. Claims submission, adjudication and reconciliation requirements;
 3. Quality management requirements;
 4. Record maintenance and retention requirements;
 5. Facility and record access requirements.
- K. Pro Care will comply with DCH's written policies adopted pursuant to the federal Deficit Reduction Act of 2005, PL 109-171 ("DRA 2005") that provide detailed information about the federal False Claims Act, federal administrative remedies for false claims and statements, Michigan Laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such Laws, with respect to the role of such federal and state Laws in preventing and detecting fraud, waste, and abuse in federal health care programs.
- L. If and when Pro Care becomes directly subject to DRA 2005, Pro Care will adopt written policies as required by DRA 2005 and will include in its employee handbook a specific discussion of the Laws described in DRA 2005, the rights of employees to be protected as whistleblowers, and Pro Care's policies and procedures for detecting and preventing fraud, waste, and abuse.
- M. Pro Care has internal processes to aid in the detection and prevention of fraud and abuse. These processes address:
 1. Authorization and claim payment;

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	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 5 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

2. Provider data entry, authorization, and claim payment;
 3. Claim payment and check production;
 4. Provider and Member profiling to identify under- or over-utilization with a focus on fraud and abuse;
 5. Review of Member and Provider grievance logs;
 6. Review of Member and Provider inquiries and complaints;
 7. Review of medical records;
 8. Check generation and check signature;
 9. Check generation and bank reconciliation.
- N. If Pro Care suspects or has knowledge of the presence of fraud or abuse in the Medicaid program, Pro Care will report the suspicion immediately to the DCH Program Investigations Section by calling (866) 428-0005 or send a letter to: Program Investigation Section, Capitol Commons Building, 400 S. Pine, 6th Floor, Lansing, MI 48909. Pro Care's report will contain the following information: (i) the nature of the complaint; and (ii) the name of the individual or entity involved in the suspected fraud or abuse, including their address, telephone number, Medicaid identification number, and other identifying information. Pro Care will inform the Program Investigations Section of the actions taken to investigate or resolve the reported suspicion, knowledge or action.
- O. Personnel, Provider and Member reports to Pro Care of suspected fraud or abuse are investigated internally in accordance with Pro Care's Internal Investigation Policy which is part of Pro Care's Compliance Program. Suspected fraud and abuse problems or concerns detected during Pro Care's monitoring activities are also investigated in accordance with Pro Care's Internal Investigation Policy.
- P. Upon request and as permitted by state and federal Laws, Pro Care will make available to authorized investigating and enforcement agencies administrative, financial and medical records relating to the delivery of

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 6 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

items or services for which federal and state Medicaid program funds are expended.

Q. Pro Care's CCO, legal counsel or other person designated by Pro Care's Board of Directors will respond to inquiries and directives by authorized state and federal fraud and abuse investigating and enforcement agencies, report to the Board, and coordinate activities with the appropriate Pro Care departments such as:

- Finance
- Health Care Management/Quality /Credentialing
- Information Technology

R. During an internal investigation or an external investigation by a state or federal investigating and enforcement agency regarding suspected fraud and abuse by a Provider, the following process will take place, as appropriate and as permitted by applicable Laws:

1. Copies of medical records related to the service(s) in question will be obtained for review.
2. Claims or capitation payments in question will be pended until the investigation is completed
3. A letter will be sent to the Provider which will include the following:
 - Details of the allegations and questions involved
 - A request for medical records, if appropriate
 - Acknowledgement of the persons or organizations involved in the investigation
 - Notification of potential consequences relative to the outcome of the investigation

S. In the event the Provider is determined to have engaged in fraud or abuse, Pro Care will initiate actions consistent with its Compliance Program, the

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	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 7 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

Medicaid program contract requirements, and applicable state and federal Laws. Such actions may include:

1. Providing notice of intent to terminate the Provider's contract;
 2. Arranging for transfer of enrollees in accordance with the enrollee transfer procedures
 3. Notifying the appropriate licensing board
 4. Allowing the Provider a fair hearing process to appeal any administrative actions taken.
- T. If a Provider is terminated from the Medicaid or Medicare programs or other state or federal health care programs due to fraud or abuse, Pro Care will take prompt steps to terminate the Provider's contract or the provision of services to Pro Care Members.
- U. Pro Care will request information from the Program Investigation Section or Health Care Fraud Division as needed to assist Pro Care in developing aggressive, proven procedures for the detection of fraud and abuse.
- V. Pro Care understands that it is permitted to disclose protected health information (PHI) to DCH or the AG without first obtaining authorization from the Member to disclose such information if the disclosure satisfies an exception under state or federal privacy and confidentiality Laws. Additionally, Pro Care understands that DCH and the AG shall ensure disclosures meet the requirements for disclosures made as part of Pro Care's treatment, payment, or health care operations as defined in 45 CFR 164.501.
- W. Pro Care will cooperate with DCH and the AG as necessary and in accordance with state and federal Laws to ensure program integrity.
- X. Pro Care will update its fraud and abuse policies and procedures as situations arise and/or Laws or the needs of Pro Care change.
- V. **MATERIALS:**
- Letter to Provider regarding investigation of alleged fraud or abuse
 - Fraud and Abuse Complaint Form

Pro Care Health Plan, Inc. (Pro Care)	
	<i>Administration</i>
	Policy & Procedure
Subject: Fraud and Abuse	Line of Business: [X] Medicaid
Approval Date: 1/31/06	
Effective Date: 2/1/06	Document Number: PC-06-630
Review Date:	Page: Page 8 of 8
Most Recent Revision: 11/30/09	
Next Review Date: 9/30/10	

VI. **REPORTING/RECORDS:** Subject to confidentiality protections as required or permitted under applicable Laws:

1. Annual reports that document the number of complaints that warrant an investigation by Pro Care each year
2. Internal and external monitoring and audit reports
3. Corrective action plans
4. Committee minutes
5. Annual reports of suspected fraud and abuse to DCH Program Investigations Section