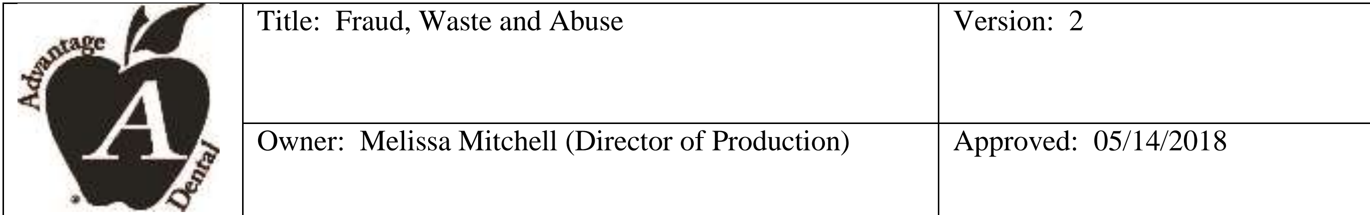

	Title: Fraud, Waste and Abuse	Version: 2
	Owner: Melissa Mitchell (Director of Production)	Approved: 05/14/2018

Purpose: The purpose of this Policy is to outline and define the scope, responsibilities and operational guidelines, controls and activities to assist in the identification and reporting of potential enrollee and/or provider Fraud, Waste and Abuse (FWA) occurrences. This Policy is established in accordance with the terms and conditions of applicable state and federal statutes and regulations, and articulates the Dental Care Organization's (DCO) commitment to comply with all federal and state rules in preventing FWA.

Responsibility: Compliance Manager, Compliance Committee and Quality Improvement (QI)/Utilization Review (UR) Committee

Scope: Advantage Dental Services, LLC (Advantage or DCO)

Definitions:

A. **Abuse**: Practices by a provider that are inconsistent with sound fiscal, business or dental health practices and result in an unnecessary cost to a health care program or in reimbursement for services that are not medically necessary, violation of an agreement or certificate of coverage, or that fail to meet professionally recognized standards for dental health care.

B. **Fraud:** The intentional deception or misrepresentation which an individual knows to be false or does not believe to be true, and makes knowing that deception could result in some unauthorized benefit to himself/herself or some other person.

C. **Incident:** A situation of possible FWA which has the potential for liability to the State of Oregon, the DCO's contractors and subcontractors.

D. **Potential:** If in one's professional judgment, it appears as if an incident of FWA has occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

E. **Waste:** Unnecessary costs incurred when dental health care services are overused or when bills for services are prepared incorrectly. Unlike fraud, waste is usually caused by error or oversight rather than illegal or intentionally wrongful actions.

Policy:

The DCO seeks to maintain the highest level of professional ethical standards, including compliance with applicable legal requirements. This policy can only be achieved with the cooperation of all personnel. The intent of this Policy is to set forth expectations, guidelines, and procedures necessary for personnel to meet this objective.

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1. Confidentiality: All information identified, researched or obtained for or as part of a potential FWA investigation of a potential FWA occurrence is maintained solely for this specific purpose and no other. The Compliance Manager is responsible for maintaining the confidentiality of all potential FWA information identified, researched or obtained, in accordance with the terms and conditions of the DCO's Limited Use and Disclosure of Protected Health Information Policy.

2. Appointment of Compliance Manager and Compliance Committee: The DCO has appointed a Compliance Manager who reports to the DentaQuest Chief Ethics and Compliance Officer. The Compliance Manager has formed a Compliance Committee that includes the Compliance Manager and members of the Advantage Management Team. This group reports regularly to the Audit, Finance and Compliance Committee (a committee of the Board of Managers) on the status of the Compliance Program, including issues identified, investigated and resolved by the Compliance Program.

A. Compliance Manager: DCO's Compliance Manager is Rose Novak. Her contact information is Compliance@advantagedental.com or 866-654-3433. The Compliance Manager, along with the VP and General Counsel, VP of Dental Services, Dental Director, and the Case Management Department, will operate and monitor the DCO's FWA program. The Compliance Manager will:

1) Communicate and coordinate with the Division of Medical Assistance Programs (MAP), the Center for Medicare and Medicaid Services (CMS), and other applicable regulatory state and federal agencies when appropriate.
2) Implement compliance with this Policy;
3) Serve as a contact for the DCO's personnel, providers, subcontractors and the general public to report any potential violations of laws, regulations or this Policy; and
4) Ensure appropriate action against violators of any such laws, regulations or this Policy.

B. Compliance Committee: This committee is chaired by the Compliance Manager and serves to advise and inform DCO's Audit, Finance and Compliance Committee. DCO's Audit, Finance and Compliance Committee is made up of Board of Managers of DCO. The Compliance Committee updates the Audit, Finance and Compliance Committee and its duties include:

1) Meeting at least quarterly to enable reasonable oversight of the Compliance Program;
2) Developing strategies to promote compliance and detection of any potential violations;
3) Reviewing and approving compliance and FWA training, and ensuring that training and education are effective and appropriately completed;
4) Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan;
5) Assisting in the creation, implementation and monitoring of effective corrective actions;
6) Reviewing the effectiveness of the system of internal controls designed to ensure compliance with laws, regulations, and policies in daily operations;
7) Ensuring that Advantage maintains up-to-date compliance policies and procedures;
8) Ensuring that Advantage has a system for compliance inquiries and report potential instances of program noncompliance and potential FWA confidentially, anonymously, and without fear of retaliation;

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9) Reviewing and addressing reports of monitoring and auditing of areas in which Advantage is at-risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness.

3. Delegation: The DCO may from time to time delegate to third-party entities responsibility for some of the activities set forth in this Policy. Such delegation shall be set forth in writing and subject to revocation and other applicable remedies when MAP or the DCO determine the delegate has not performed its obligations satisfactorily. These written delegation agreements shall, in addition, contain provisions granting the DCO inspection rights, protecting plan enrollees, assuring both the DCO and the delegate's accountability, and requiring the delegate to satisfy all record retention requirements. In no event shall the DCO delegate its Compliance Manager or compliance committee functions to any third party. In all instances, third-party delegates generating claims data as part of their delegated responsibilities shall certify to MAP the accuracy, completeness, and truthfulness of that data, and acknowledge that the data will be used for the purposes of obtaining federal reimbursement. Finally, in all cases of delegation, the DCO understands that it remains ultimately responsible to MAP for all activities and responsibilities delegated to third parties.

4. Subcontracting: The DCO shall ensure that all subcontracts meet the requirements described below and shall incorporate portions of the DCO Contract, as applicable, based on the scope of work to be subcontracted:

A. The DCO may subcontract any or all of the work to be performed under its DCO contract. However, subcontracting does not terminate or limit the DCO's legal responsibility to MAP for the timely and effective performance of the DCO's duties and responsibilities under the DCO Contract.

B. Before subcontracting any work, the DCO shall evaluate the prospective subcontractor's ability to perform the work under a subcontract.

C. The DCO shall have a written agreement (subcontract) that specifies the subcontracted work and reporting responsibilities of the subcontractor. The DCO shall notify the Oregon Health Authority (OHA) in writing of work to be subcontracted.

5. Code of Conduct and Ethics: The DCO expects all its employees, contractors, officers, and Board members (affiliated individuals) to act with the highest degree of integrity at all times. To further this expectation, the DCO recognizes the following principals and standards of behavior:

A. Whenever DCO business is involved; affiliated individuals shall put the wellbeing of the DCO ahead of their own self-interest;

B. Affiliated individuals shall immediately alert and advise other involved affiliated individuals regarding any conflict of interest they may have with respect to the business of the DCO. This includes any of the DCO's business that may benefit them, their business, their family members, or friends. Full and complete disclosure is expected.

C. Unless asked to continue participating in the particular business at hand, the affiliated individual shall withdraw from discussions or decisions relating to the conflict of interest;

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D. Affiliated individuals shall not accept gifts or other forms of value from any vendor, service provider, or other person doing business with the DCO or its shareholders exceeding nominal amounts as indicated in the Advantage Code of Conduct and Ethics.

E. Nothing in these standards shall be interpreted to prohibit a provider from offering the provider's dental judgment regarding any dental matter, regardless of the nature of the provider's practice, or from providing legitimate peer review, credentialing, or dental oversight services.

6. Annual Review: Contractor shall review its FWA policies annually and submit a written copy to MAP's Quality Assurance and Improvement Unit, by May 1st of the Contract year and to any Coordinated Care Organization as requested.

7. Applicable Laws and Regulations: The chart below summarizes some of the many state and federal laws and regulations impacting the DCO's activities. The overarching principal underlying each of the listed laws is the obligation to act honestly and in good faith in dealing with the government, payors, enrollees, providers, and coworkers and to take affirmative steps to avoid, and as necessary detect, activities which may be dishonest, deceitful, fraudulent, or otherwise involve theft or ill-gotten gains. Affiliated individuals are obligated to avoid any conduct in violation of the listed statutes, and immediately report activities they observe that violate the listed laws.

A. Criminal Conduct:

Statute Name and Number	Description of Prohibited Activity	Penalties
Federal False Claims Act 31U.S.C. 3729-3733	(1) Knowing submission of any false or fraudulent claim for payment to the United States; (2) knowing use of a false record or statement to obtain payment of a false or fraudulent claim; or (3) any conspiracy to defraud the United States through false or fraudulent claims.	Up to 5 years in prison, repayment of all ill-gotten gains, and fines up to $25,000.
Bribery, Perjury and related offenses ORS 162.015-ORS 162.119	(1) Offering or accepting any benefit to influence any public official; (2) any sworn false statements or written false statements if made to a public official.	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to $250,000.
Theft Related Crimes ORS 164.015-ORS 164.174	(1) Taking property from the lawful owner; (2) keeping property of another mistakenly left or lost; (3) obtaining money through extortion or deception; (4) receiving and keeping property knowing that the property was the subject of theft; (5) obtaining services without payment knowing that the services were offered only in exchange for compensation; (6) participating in laundering of unlawfully obtained monies.	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to $250,000.
Fraud or Deception ORS 165.002-ORS 165.042	Prohibits forgery, which includes (1) the intent to injure or defraud, making, completing, or altering any document, or	Up to 10 years in prison, repayment of all ill-gotten gains, and fines up to

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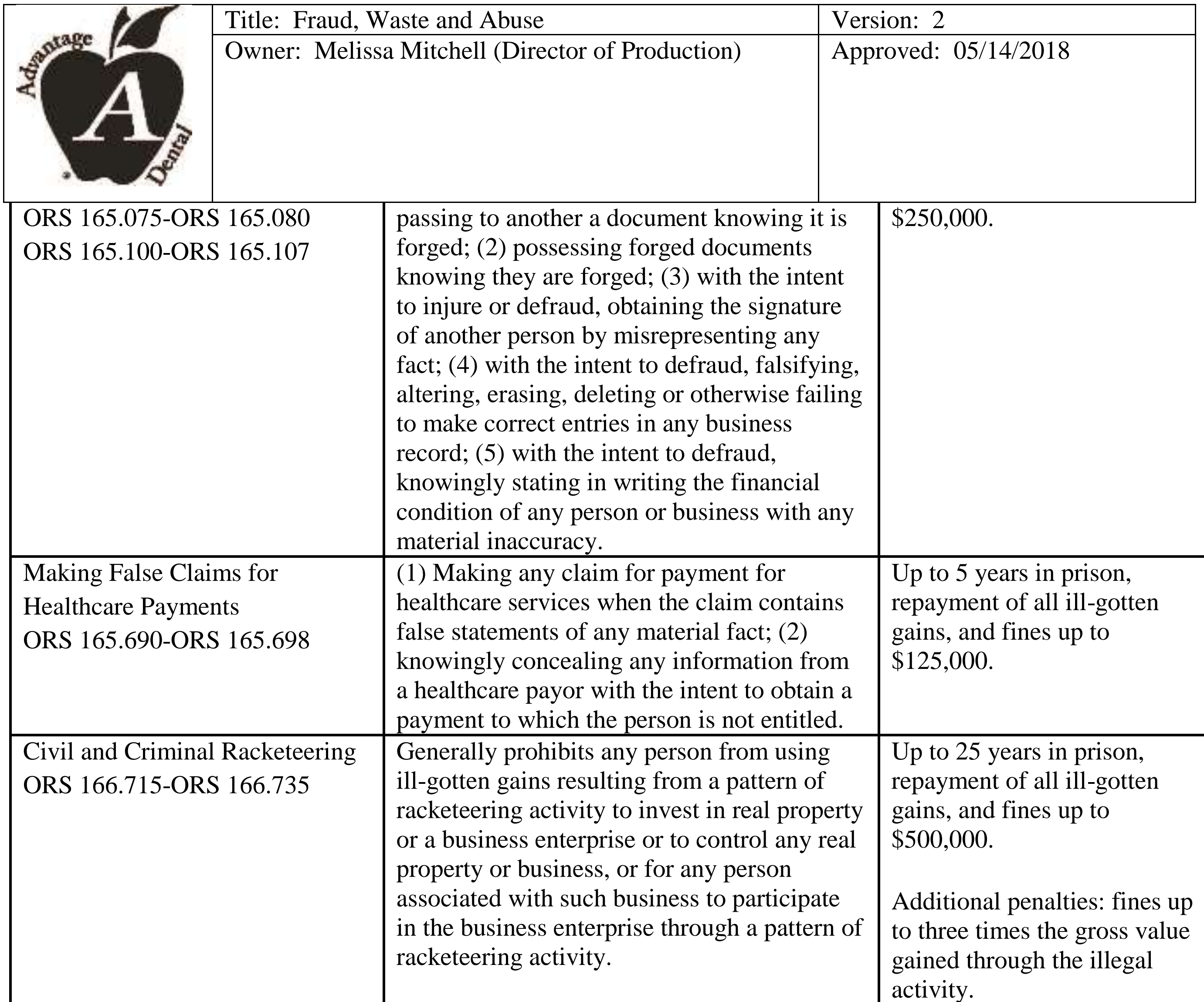

ORS 165.075-ORS 165.080 ORS 165.100-ORS 165.107	passing to another a document knowing it is forged; (2) possessing forged documents knowing they are forged; (3) with the intent to injure or defraud, obtaining the signature of another person by misrepresenting any fact; (4) with the intent to defraud, falsifying, altering, erasing, deleting or otherwise failing to make correct entries in any business record; (5) with the intent to defraud, knowingly stating in writing the financial condition of any person or business with any material inaccuracy.	$250,000.
Making False Claims for Healthcare Payments ORS 165.690-ORS 165.698	(1) Making any claim for payment for healthcare services when the claim contains false statements of any material fact; (2) knowingly concealing any information from a healthcare payor with the intent to obtain a payment to which the person is not entitled.	Up to 5 years in prison, repayment of all ill-gotten gains, and fines up to $125,000.
Civil and Criminal Racketeering ORS 166.715-ORS 166.735	Generally prohibits any person from using ill-gotten gains resulting from a pattern of racketeering activity to invest in real property or a business enterprise or to control any real property or business, or for any person associated with such business to participate in the business enterprise through a pattern of racketeering activity.	Up to 25 years in prison, repayment of all ill-gotten gains, and fines up to $500,000. Additional penalties: fines up to three times the gross value gained through the illegal activity.

B. Civil (Non-Criminal) Conduct:

False Claims Act Title 31, Chapter 38 of the United States Code	(1) Knowing submission of any false or fraudulent claim for payment to the United States; (2) knowing use of a false record or statement to obtain payment of false or fraudulent claim; or (3) any conspiracy to defraud the United States through false or fraudulent claims.	Fines between $5,500 and $11,000 per claim filed, plus three times the lost value resulting from the false or fraudulent claim.
False Claims for Public Assistance ORS 411.670-ORS 411.690	(1) Knowingly submitting false claims for public assistance benefits; (2) knowingly submitting claims for public assistance which have previously been paid or submitted without clearly indicating they are duplicates; (3) knowingly accepting any payment for public assistance not actually provided.	Repayment of up to three times the amount of wrongfully received assistance.
Unlawful Trade Practices ORS 646.605-ORS 646.652	Generally prohibits (1) any unconscionable tactics in connection with the sale of any goods or services; (2) failing to deliver any	While violations may be prosecuted by a District Attorney, these violations are

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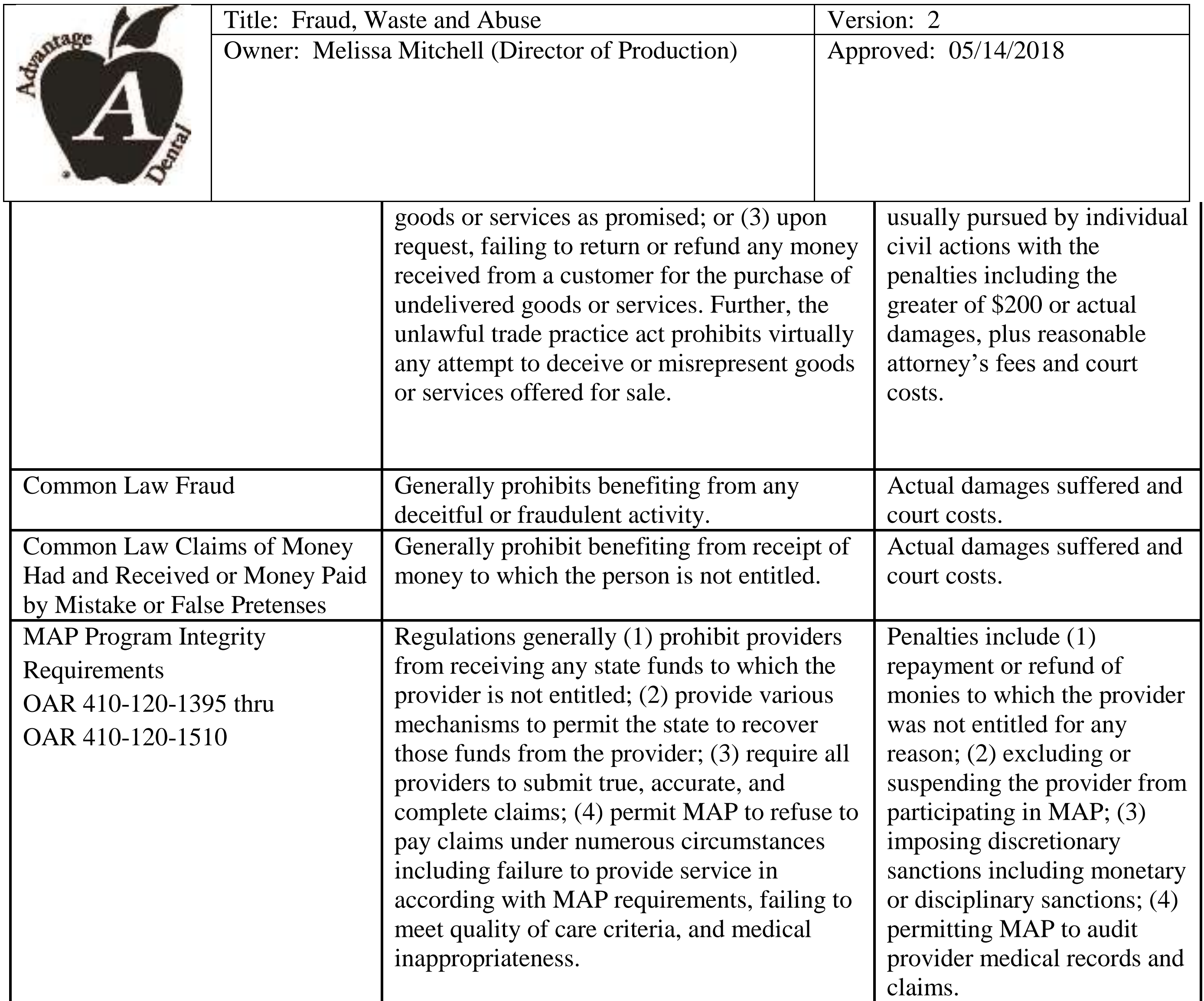

	goods or services as promised; or (3) upon request, failing to return or refund any money received from a customer for the purchase of undelivered goods or services. Further, the unlawful trade practice act prohibits virtually any attempt to deceive or misrepresent goods or services offered for sale.	usually pursued by individual civil actions with the penalties including the greater of $200 or actual damages, plus reasonable attorney's fees and court costs.
Common Law Fraud	Generally prohibits benefiting from any deceitful or fraudulent activity.	Actual damages suffered and court costs.
Common Law Claims of Money Had and Received or Money Paid by Mistake or False Pretenses	Generally prohibit benefiting from receipt of money to which the person is not entitled.	Actual damages suffered and court costs.
MAP Program Integrity Requirements OAR 410-120-1395 thru OAR 410-120-1510	Regulations generally (1) prohibit providers from receiving any state funds to which the provider is not entitled; (2) provide various mechanisms to permit the state to recover those funds from the provider; (3) require all providers to submit true, accurate, and complete claims; (4) permit MAP to refuse to pay claims under numerous circumstances including failure to provide service in according with MAP requirements, failing to meet quality of care criteria, and medical inappropriateness.	Penalties include (1) repayment or refund of monies to which the provider was not entitled for any reason; (2) excluding or suspending the provider from participating in MAP; (3) imposing discretionary sanctions including monetary or disciplinary sanctions; (4) permitting MAP to audit provider medical records and claims.

8. Whistle Blowing Rights: Affiliated individuals are encouraged and obligated to report any violation or suspected violation of any of the above laws or regulations committed in the course of the DCO's business to the DCO's Compliance Manager. The False Claims Act, referenced in the chart above, prohibits the DCO from taking any action against employees who makes such a report if that action would negatively impact the terms and conditions of their employment. Further, ORS 659(A).230 – ORS 659(A).233 and ORS 659(A).200 – ORS 659(A).224 assure that employees may, in good faith, report any criminal activity, provide evidence and testify in any related proceedings without fear of any negative impact on employment. If you believe or suspect that any retaliatory or other action may be taken against you or may have been taken against you because of these protected activities, you should immediately notify the Compliance Manager. If you believe the Compliance Manager is complicit, you should instead report your concerns to the DentaQuest Chief Ethics and Compliance Officer or DCO's Chief Executive Officer (CEO).

9. FWA Detection, Correction and Prevention Policies and Procedures: To articulate its commitment to detect, correct and prevent FWA, the DCO will:

A. Distribute this Policy and all other written policies and procedures related to FWA to all DCO personnel at time of hire or contract, when the standards are updated, and annually thereafter. As a

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condition of employment, employees shall certify that they have received, read, and will comply with all written policies and procedures, including this Policy;

B. Require DCO's personnel to sign a statement, attestation or certification related to conflict of interest at time of hire or contract and annually thereafter;

C. Maintain policies that require review of the U. S. Department of Health & Human Services Office of Inspector General (DHHS OIG) and General Services Administration (GSA) exclusion lists on a monthly basis to ensure that DCO's personnel are not included on such lists. If DCO's personnel are on such lists, DCO's policies require their immediate removal from any work on health care programs;

D. Establish procedures for the identification of FWA in DCO's network, including internal monitoring and auditing such as: (1) interviewing personnel, (2) reviewing incident reports and complaint logs, (3) auditing charts from providers on a monthly basis by looking at the chart vs ledger and services provided, waivers for non-covered services, radiographs, procedure codes vs billed services, and (4) send out monthly verification of services letters on a random sample of claims;

E. Maintain procedures for referring instances of potential FWA to the appropriate authority for further investigation;

F. Develop and implement an effective training program for employees, providers and subcontractors; all new employees, providers and subcontractors shall be trained on fraud, waste and abuse within 30 days of being hired or contracting. DCO will have regular, effective education and training for employees, contractors, and providers. Employees will review training once a year or when there are any significant changes in the requirements. Employees that are involved in compliance activities and risk areas may attend trainings, classes, conferences and seminar on compliance issues as needed. In addition, employees involved in compliance have access to numerous resources including; outside legal counsel, Westlaw, Health Care Compliance Association (HCCA), DHHS Website, CMS Website, and the Society of Corporate Compliance and Ethics in addition to Advantage Compliance policies.

G. Publicize disciplinary guidelines for enforcing this Policy and all other policies and procedures;

H. Develop a process to receive complaints and protect the anonymity of any complainant; Employees should report any suspicion of fraud, waste or abuse to their direct supervisor, Compliance Manager or through the anonymous Fraud Hotline at 1-855-FRAUD-HL, Company Code ("Advantage"). The purpose of the Fraud Hotline is to provide employees and providers with an avenue in which to report potential incidents of fraud in an anonymous manner. Reports can be made, in person, via email, by mail or by phone. Providers may report suspicion of fraud, waste or abuse to Advantage via the grievance and appeal process, by reporting to the Compliance Manager or through the anonymous Compliance AlertLine at 1-866-654-3433. Enrollees may report suspicion of FWA as described in Section 14(A) below. DCO will protect the anonymity of a complainant to the best of its ability. (See Section 14 D below for more information). If an employee, provider or enrollee does not feel comfortable following the procedure above they can contact the following people;

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Department of Justice – Medicaid Fraud Control Unit (MFCU)
1515 SW 5th Avenue, Suite 410
Portland, Oregon 97201
Phone: 971-673-1880
FAX: 971-673-1890

OHA/DHS Fraud Investigation
P.O. Box 14150
Salem, Oregon 97309-5027,
Phone: 1-888-FRAUD01 (888-372-8301),
FAX: 503-373-1525 ATTN: HOTLINE

Coordinated Care Organization (CCO). DCO will work with the CCO on matters of suspected FWA and shall work with the CCO in referrals to the MFCU if the circumstances warrant such a referral.

I. Develop a system for responding to allegations and imposing appropriate discipline or sanctions for violations. When a complaint is made, the Compliance Manager will review and investigate the complaint by contacting the necessary parties to assess the validity of the complaint. If it is determined that the complaint requires disciplinary action be taken, the type of disciplinary action will depend on the type and severity of the violation. Disciplinary action may include but is not limited to mandatory training, re-training, suspension and/or termination and possibly restitution in cases involving providers. (See Section 15 below for more information). Violation of this policy may result in disciplinary or corrective action against those employees, providers, associates, subcontractors, directors, enrollees or related entities who participate in non-compliant behavior including illegal, fraudulent, improper, dishonest, or unethical activities. The investigative process may include, but is not limited to, the following: (1) gathering of information and documents located in different departments, areas, or sources; (2) interviewing interested parties for the purpose of receiving information about any allegation made, confirmation of fact alleged, credibility assessment of witnesses and (3) determination as to the best approach. (See Section 14 A and B for further information);

J. Use risk evaluation to monitor compliance and proactively reduce any problem areas; This may include; (1) monitoring compliance and tracking incidents of noncompliance, (2) using a risk valuation/assessment checklist, (3) an examination of the occurrence of closely related issues to determine if there is a pattern, and (4) monitor corrective actions over time to ensure its effectiveness in preventing errors. Risks are identified through various sources including, but not limited to: external and internal audits, internal monitoring and metrics reporting, identification of compliance issues by CMS and internally;

K. Develop corrective action procedures to promptly respond to detected offenses and initiate corrective action. When a risk evaluation or audit uncovers areas needing improvement, the appropriate actions may be taken including training, retraining, education, suspension or termination if necessary. (See Section 14 C below for further information).

L. Describe the arrangements for identifying overpayments and making repayments to the appropriate party. The claims processing system is set up to catch any duplicate claims. In addition, spot checks

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are performed on billing and insurance payments. A provider is also sent a remittance with the amount bill out so the provider can reconcile the claim and the payment. If a discrepancy is notice, the claims processing department follows up. If an overpayment is made, the claims processing department seeks a refund within 60 calendar days after the overpayment has been identified. Each provider agreement requires the provider to repay any overpayments back to DCO or DCO may pursue its remedies under the law.

M. Promptly notifying the State when information is received about changes in an enrollee's circumstances that may affect the enrollee's eligibility including changes in enrollee's residence and the death of an enrollee.

10. Hiring and Contracting: Prior to hiring employees or entering into subcontracts, DCO will review the U. S. Department of Health and Human Services Office of the Inspector General (OIG) and General Services Administration (GSA) exclusion lists (Exclusion Lists) to be sure the individual has not previously been sanctioned for involvement with fraudulent or abusive practices involving the provision of dental services and conduct background checks to ensure that no history of engaging in illegal or unethical behavior exists. In addition, applicants shall be required to certify in writing that they have not previously been convicted of any crime involving Medicare fraud and have not previously been sanctioned. DCO will not knowingly employ or contract with excluded individuals and entities. Accordingly, DCO has implemented procedures to immediately remove affiliated individuals that have been convicted or excluded from participation in federal health programs from any work on all health care programs.

11. Education: During orientation, all newly affiliated individuals shall be provided a copy of this Policy. For employees, a supervisor shall review with the new hire all portions of this Policy relevant to the employee's position. Upon transfer to other positions, the relevant supervisor shall again review with the employee those portions of the Policy relevant to the employee's new position. For Providers and Subcontractors, this Policy will be reviewed with them at time of contracting or during the training period, whichever is more appropriate. DCO shall annually provide review and training in all matters relating to its FWA prevention procedures and programs, including this Policy. The Compliance Manager shall be responsible for planning and shall assist in providing these annual reviews. All affiliated individuals shall be required to demonstrate attendance at one review at least annually. Reviews shall emphasize, among other things, reporting obligations and applicable procedures for reporting suspected violations within the organization. Training will include information on the compliance program itself and applicable statutes and regulations.

A. Documentation: DCO shall maintain documentation of all educational activities, including a record of dates, times, attendance, materials distributed and agenda for all professional and compliance training sessions in which DCO's personnel, subcontractors or providers participate.

B. Compliance Reference Materials: The Compliance Manager shall maintain a library of regulatory and compliance-related information and training manuals. This information includes carrier newsletters, Medicare manuals, federal regulations, HCFA interpretations, and materials published by the American Dental Association and other relevant professional societies. The Compliance Manager is also responsible for regularly disseminating new compliance information to DCO's personnel, providers and subcontractors.

12. Reporting Mechanisms and Primary Contact:

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A. As appointed by the Board of Managers, DCO's Compliance Manager coordinates all FWA information transfers between DCO, the MAP Medicaid Fraud Control Unit (DMFCU), and other applicable regulatory state and federal agencies, including CMS and DHS Provider Audit Unit (PAU), when appropriate.

B. Any potential FWA occurrences identified by an affiliated individual, plan member, or any other individual or group during the course of performing DCO duties are to be initially reported to the Compliance Manager. The affiliated individual will send the report to the Compliance Manager for review and forwarding to DMFCU, CMS, PAU, and other applicable reporting agencies in accordance with their procedures and requirements.

13. FWA Report Response Procedure: The following summarized procedures are non-inclusive. Further detailed and additional steps may be performed as the specific circumstances within each case warrant.

A. Enrollees: Upon receipt of report of FWA by an enrollee, the Compliance Manager shall conduct and coordinate an investigation, including but not limited to the following:

1) Review enrollee demographic database information (county of residence, rate code, eligibility segments, age/date of birth, gender, PCP).
2) Review enrollee claims history for a period not less than 12 months previous to month of receipt of referral.
3) Obtain necessary information based upon the category of the referral (such as citizenship, residency, household composition, income, employment, resources, dental issues, pharmacy issues, transportation or health plan identification card abuse).
4) Contact internal committees for relevant information or discussion (case management, enrollee services department, complaint or grievance history, provider services, pharmacy information, department managers).
5) Obtain necessary information from outside sources as circumstances warrant.
6) Perform determined necessary audit steps of encounters, billing, dental, procedure coding or other information as circumstances warrant to develop data for further analysis and decision.
7) Review assembled case file information and make referral assessment decision.
8) If circumstances and data warrant referral, forward to DMFCU or CMS as appropriate.
9) If circumstances and data do not warrant referral, case is closed; the retained case file will include summary of non-referral decision factors.
10) Provide feedback to the Management Committee, QI Committee and CEO, as appropriate.
11) The procedures are applicable to referrals for all lines of business.
12) Persons or entities currently debarred or otherwise excluded under the Federal Acquisition Regulation, Persons or entities currently suspended or terminated from MAP or excluded in the Medicare program, Persons who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, *XIX (was listed)* or XX of the Social Security Act and/or related laws (or entered a plea of nolo contendere), will have their payments suspended if DCO is aware of credible allegations of fraud which are pending investigation by MFCU.

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B. Providers\Subcontractors herein referred to as "provider". Upon receipt of a report of FWA by a provider, the Compliance Manager conducts and coordinates an investigation, including but not limited to the following:

1) Review provider database information (county of practice, provider ID#, tax ID#, contract status, provider type/specialty).
2) Review provider contract, if applicable.
3) Review provider claims history/reconciliation report for a period not less than 12 months previous to month of receipt of referral.
4) Obtain necessary information based upon the issue/incident raised (such as dental abuse or financial/billing/encounters/coding abuse).
5) Contact internal committees for relevant information or discussion (case management, quality management, provider services, provider file, enrollee services, complaint and grievance history, department managers or senior management as circumstances warrant)
6) Obtain necessary information from outside sources as circumstances warrant.
7) Perform determined necessary audit steps of encounters, billing, dental procedure coding or other information as circumstances warrant to develop data for further analysis and decision.
8) Review assembled case file information and make referral assessment decision.
9) If circumstances and data warrant referral, forward to DMFCU DHS Fraud Investigation Unit, DHS Provider Audit Unit or CMS, or other applicable regulatory state and federal agencies as appropriate.
10) If circumstances and data do not warrant referral, case is closed; case file will include summary of non-referral decision factors.
11) Provide feedback to the Management Team, QI Committee, and CEO, as appropriate.

C. Corrective Action: Corrective Action should be taken promptly following completion of the investigation. If an audit or investigation reveals a material violation of this Policy, the Compliance Manager and Legal Counsel shall draft a corrective plan of action, and establish deadlines by which corrective action must take place. All corrective actions shall be documented, and include progress reports with respect to each error identified. Any decision whether to disclose the results of investigations or audits to federal or state authorities shall be made by the Board of Managers based upon recommendations of Legal Counsel. Possible corrective actions include, but are not limited to:

1) Appropriate disciplinary action;
2) Referral of any abusive or potentially fraudulent conduct to DMFCU for further investigation;
3) Immediate reporting of potential violations of law to appropriate law enforcement authorities; Identification and repayment of any overpayments to the appropriate party; and
4) Removal of any DCO personnel, providers, subcontractors or enrollees who engage in fraudulent or abusive practices from any work on health care programs.

D. Anonymity: DCO will take all reasonable steps necessary to protect the anonymity of persons filing incident reports or otherwise reporting suspected FWA. Original reports containing the referring individual's identifying information shall be maintained in a secure file accessed only by the Compliance Manager and persons expressly assigned to assist with the investigation. All parties involved with a referral investigation shall protect from disclosure original reporting documents and

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any other material including information identifying the referrer and shall otherwise protect the name and identification of the reporter and avoid disclosure. At the conclusion of investigations, all documents and records containing identifying information shall be sealed and maintained in a secure file in accordance with DCO document retention policies.

14. Discipline and Retaliation:

A. Prohibition and Enforcement: DCO cannot knowingly tolerate FWA among its employees and providers or within programs and plans it sponsors or participates in. Hence, this Policy and related FWA identification and reporting activities are essential to the organization's ongoing integrity and wellbeing. To accomplish these objectives, DCO, through its Compliance Manager, employees and all its affiliated individuals, intends to strictly enforce this Policy. All affiliated individuals must immediately report violations of the Policy to the Compliance Manager and fully cooperate with the Compliance Manager's investigation. Failure to do so is itself a violation of this Policy subject to discipline.

B. Promotion of Standards: DCO shall, under the direction of the Compliance Manager, ensure that the disciplinary guidelines developed and implemented under this Policy are well-publicized to all affiliated individuals. This may be accomplished through:

1) The release of newsletters that explain FWA;
2) Discussing this Policy at staff meetings
3) Displaying posters and notices in common areas;
4) E-mails;
5) Other appropriate methods of communication; and
6) Posting information about FWA and reporting methods on DCO's Intranet and Internet web sites.

C. Disciplinary Options: DCO shall determine whether a violation has occurred and the facts related to that violation after reasonable investigation. Where violations are documented, the offender shall be disciplined through oral or verbal reprimands, suspension or termination. The severity of discipline shall depend upon the specific circumstances of the violation, the offender's prior history of violations, the offender's motivation, and the nature and degree of the current and prior violations. All violations shall be documented and retained in the employee's personnel file. Possible disciplinary action may include, but shall not be limited to, documented warnings (oral); reprimands (written); probation; demotion; suspension without pay; referral to counseling; withholding of a promotion or salary increase or other financial penalties; termination; failure to renew agreements; contract termination; restitution of damages; and referral for criminal prosecution to law enforcement agencies, CMS or MAP as appropriate.

D. Retaliation: Employees may report violations without fear of retaliation. Retaliation for reporting violations or suspected violations, or participating in investigations regarding violations, is strictly prohibited and is itself a violation of this Policy. Retaliation or attempts to retaliate should be reported immediately to the Compliance Manager; if the Compliance Manager is involved in the retaliation, the victim should instead report the retaliation to DCO's CEO; if the Compliance Manager and CEO are involved in the retaliation, the victim should report the retaliation to the Board of Managers.

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E. Payment Suspension: If there are credible allegations pending MFCU investigation, DCO will suspend payments unless OHA determines otherwise.

15. Audits:

A. Internal Audits and Monitoring: Monitoring activities means on-going reviews to confirm compliance and ensure that corrective actions are undertaken and effective. Monitoring activities may occur to ensure corrective actions are undertaken when necessary or to ensure ongoing compliance when no specific problems have been identified. The Compliance Manager will conduct an internal audit at least annually to determine appropriate levels of compliance with its policies and procedures and to identify any shortcomings. Internal monitoring/auditing activities may be announced or unannounced and could include the following activities:

1) Personal interviews with at least five DCO staff employees, providers or subcontractors;
2) Review of all incident reports filed and all investigation files created during the year;
3) Review and evaluation of discipline imposed during the prior three years for violations of the Policy;
4) Review of contacts with governmental agencies receiving FWA reports from DCO;
5) Review of the forms, logs, and other documentation used in implementing the Policy;
6) Review of prior authorizations, claims and utilization management; and
7) Such other review and inquires as the Compliance Manager deems appropriate.

B. The contacts and reviews shall be designed to determine whether staff, providers and subcontractors understand and are acting in accordance with the Policy and its requirements, whether the Policy is effectively minimizing FWA activities, whether DCO's staff, providers and subcontractors are reporting violations and whether those violations are being dealt with appropriately and effectively, whether the Policy remains up-to-date and continues to meet MAP's and CMS's needs and expectations and otherwise complies with applicable contracts, and whether the Policy is successfully creating an atmosphere conducive to compliance with all applicable rules and regulations.

C. Review and Modification: After completion of the audit and review, the Compliance Manager shall promptly report findings to DCO's senior management and QI Committee. The Compliance Manager and senior management shall together review applicable contract requirements to determine whether the Policy and its implementation require improvement, modification, or updates. Resulting recommendations to amend the Policy shall be reported to the Board of Managers with suggested Policy modifications; changes in the Policy shall be developed and implemented by the Compliance Manager after review and approval by the CEO. The Compliance Manager shall review the effectiveness of changes and modifications no later than six months after their implementation and shall report to the results to the CEO. The CEO and the Compliance Manager shall thereafter work together to design and implement any additional changes necessary to achieve the objectives.

D. External Auditing: DCO's Compliance Manager shall coordinate external audits. All employees, providers and subcontractors shall cooperate with external audits and monitoring. Audits may be performed by external auditors with expertise in federal and state health care statutes, regulations, and

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policies. The external auditor shall be independent of DCO's management and have complete access to records and personnel.

E. Risk Assessment: DCO shall utilize a risk assessment system to determine where DCO is at risk for FWA, and prioritize the risks. The Compliance Manager shall participate in or contribute to the risk assessment process. Part of the goal of DCO's system of ongoing monitoring and auditing shall be to assess performance in, at a minimum, areas identified as being at risk. The processes used to implement the risk assessment system shall be documented and available, upon request, to CMS or MAP.

F. Documentation: All efforts to comply with applicable statutes and regulations shall be documented, including the fact that an audit has taken place and a description of the nature and results of the audit. Any inquiries DCO makes of third party payors or Medicare carriers regarding the claim submission process shall be documented if DCO intends to rely on the guidance. DCO or its designee will engage in data analysis to identify patterns of aberrant and potentially abusive utilization or business practice. When data analysis reveals the potential for FWA, DCO must refer these leads promptly pursuant to paragraph 17 below. Documentation of how internal monitoring and auditing for FWA, including data analysis procedures, may be requested upon internal, external, MAP or CMS audit.

G. Explanation of Benefits: DCO shall send out explanations of benefits (EOBs) in a format approved by MAP on a monthly basis. Pursuant to 42 CFR 433.116, within 45 days of the payment of claims, the EOBs will be sent out to a sample of 10% of enrollees who received services based on claims paid in a given month. The EOB notices shall specify the following: (1) the service furnished; (2) the name of the provider who furnished the service(s); (3) the date on which the service was furnished; and (4) the amount of the payment made by the MAP enrollee, if any, for the service. The sample EOB notice shall not include specially protected information such as genetic, mental health, alcohol and drug treatment information or HIV/AIDS information. Attached is a sample of the EOB notice that has been approved by MAP.

H. DCO monitors its provider credentialing and contracting process. See credentialing policy for details of the credentialing process. The DCO Dental Director reviews each provider's credentialing before a contract is executed with a provider. If the Dental Director finds anything that could be a potential concern that was found during the credentialing process the information is taken to the QI Committee for further review and approval or denial. The QI Committee reviews and approves all providers that are contracted.

16. Referral Policy: As set forth above, DCO shall promptly refer suspected cases of FWA, including fraud by its employees, providers, and subcontractors, to the DMFCU, CMS where applicable, and the DHS Provider Audit Unit (PAU) where applicable. In determining whether to make referrals, DCO and its Compliance Manager shall consider the following:

A. Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20 percent or more of sampled or audited services are not supported by documentation in the clinical records. This would include any suspected case where it appears that the provider knowingly or intentionally did not deliver the service or goods billed.

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B. Providers who consistently demonstrate a pattern of intentionally reporting overstated or up-coded levels of service. A pattern would be evident by 20 percent or more of sampled or audited services that are billed at a higher-level procedure code than is documented in the clinical records.

C. Any suspected case where the provider intentionally or recklessly billed DCO more than the usual charge to non-Medicaid recipients or other insurance programs.

D. Any suspected case where the provider purposefully altered, falsified, or destroyed clinical record documentation for the purpose of artificially inflating or obscuring his/her compliance rating or collecting Medicaid payments otherwise not due. This would include any deliberate misrepresentation or omission of fact that is material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the enrollee or provider.

E. Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to MAP enrollees.

F. Primary Care Providers who intentionally misrepresent dental information to justify referrals to other networks or out-of-network providers when they are obligated to provide the care themselves.

G. Providers who intentionally fail to render dentally appropriate covered services that they are obligated to provide MAP enrollees under their subcontracts with the DCO and under Oregon Health Plan (OHP) regulations.

H. Providers who knowingly charge MAP enrollees for services that are covered services or intentionally balance-bill a MAP enrollee the difference between the total fee-for-service charge and DCO's payment to the provider, in violation of MAP rules.

I. Situations where the provider intentionally submitted a claim for payment that already has been paid by MAP or DCO, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the claim form, and receipt of payment is known to the provider.

J. Any case of theft, embezzlement, or misappropriation of Title XIX or Title XXI program money.

K. Evidence of corruption in the enrollment and disenrollment process, including efforts of state employees or contractors to skew the risk of unhealthy enrollees toward or away from one of the MAP contractors.

L. Attempts by any individual, including employees and elected officials of the State, to solicit kickbacks or bribes, such as a bribe or kickback in connection with placing a MAP member into a carved out program, or for performing any service that the agent or employee is required to provide under the terms of his employment.

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17. Post-Referral Requirements:

A. DCO shall comply with, and shall ensure that all employees, providers, and subcontractors comply with all enrollee abuse reporting requirements and fully cooperate with the state for purposes of all applicable laws and administrative rules. B. After referring to the DMFCU or CMS, as appropriate, DCO shall do all of the following:

1) Promptly report all identified FWA activity.
2) Permit the DMFCU or the Department of Human Services (DHS), or both, to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of DCO or by or on behalf of any subcontractor, as required to investigate an incident of FWA.
3) Cooperate and require its employees, providers, and subcontractors to cooperate with the DMFCU and DHS investigator during any investigation of FWA.
4) In the event DCO reports suspected fraud, or learns of a DMFCU or DHS investigation, it will not prematurely notify or otherwise advise the employee, provider, or subcontractor under investigation of the investigation.
5) Provide copies of reports or other documentation, including those required from the employee, provider, or subcontractors regarding the suspected fraud at no cost to DMFCU or DHS during an investigation.

18. Coordination with Governmental Agencies: DCO shall assist various governmental agencies, as practical, in providing information and other resources during the course of investigations of potential provider or enrollee FWA. These agencies include but are not limited to: MAP, Medicaid FWA Unit, Oregon Attorney General's Office, CMS, and the United States Office of the Inspector General. DCO shall coordinate all information requests and reporting, whether initiated internally or externally.

Approvals:

Date: 05/14/2018

Approved by:
Melissa Mitchell (Director of Production), Director of Production, Production

Reviewed and Revised

04/26/2013	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
05/21/2014	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2015	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Laura Donadio
02/23/2016	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Jeff Dover
02/14/2017	Jeanne Dysert	Tamara Kessler	Missy Mitchell	
03/17/2017	Quality Improvement Committee			
03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak

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