



VNS Health Health Plans

FRAUD, WASTE & ABUSE DETECTION MANUAL

Developed for use by VNS Health Health Plans Directors, Officers, Managers and Staff, including Claims, Underwriting, Member Services, Utilization and Care Management, Compliance, Grievance and Appeal and Investigative Personnel.

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TO REPORT SUSPECTED FRAUD, WASTE AND ABUSE:

Telephone: 1-888-634-1558

EthicsPoint Web Portal:

www.vnshealth.ethicspoint.com

Write to:

**VNS Health Health Plans
Attn: Special Investigations Unit 220
East 42nd Street
6th Floor
New York, NY 10017**

INTRODUCTION

Fraud, Waste and Abuse (FWA) is a significant concern for VNS Health Health Plans and the entire health insurance industry, including Medicare Advantage and Medicaid Managed Care programs.

The Centers for Medicare & Medicaid Services (CMS), the FBI, and National Health Care Anti-Fraud Association (NHCAA) all estimate that tens of billions of dollars are lost to health care fraud every year.

The New York State Office of the Medicaid Inspector General (OMIG) reported that in 2022 it generated nearly \$3.4 billion in Medicaid recoveries and cost savings. As of September 30, 2022, the Medicare Fraud Strike Force recovered \$4.7 billion through 2,688 criminal actions and 383 criminal indictments.

As the costs of health care rise, FWA prevention and detection is critical to ensuring continued coverage for New Yorkers who rely on Medicare and Medicaid—3.8 million and 7.9 million enrollees, respectively, as of March 2023.

This Fraud, Waste and Abuse Detection Manual outlines how everyone at VNS Health Health Plans can do their part to address FWA, and describes the robust systems VNS Health Health Plans has in place, and in implementation, to detect and investigate FWA.

I. FRAUD, WASTE AND ABUSE – OVERVIEW

1. What is Fraud Waste and Abuse?

Fraud is an intentional deception, concealment or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.

Waste includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.

Abuse is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.

Together, Fraud, Waste and Abuse are often referred to as **FWA**. Examples of FWA include:

- **By Providers:**

- Billing for services not provided;
- Deliberately filing incorrect diagnoses;
- Upcoding procedures to more complex services;
- Propagating or failing to address quality of care issues;
- Failure to maintain adequate medical records;
- Unbundling services to increase revenue when a more appropriate code exists;
- Misrepresenting services or dates of service;
- Billing non-covered services as covered services;
- Ineligible or excluded providers rendering services and billing under an eligible provider's identifier;
- Providing and billing for unnecessary testing and services;
- Making "cluster visits" (i.e., multiple visits within a short time);
- An absence of routine care services;
- Billing for more time (e.g., anesthesia, psychotherapy) than provided;
- Duplicate billing of more than one insurer for the same patient;
- Not crediting durable medical equipment (DME), supplies and prescription drugs back to the insurer when the original was not picked up;
Re-selling DME, supplies or prescription drugs when the items were not received by the patient and the insurer was not credited;

- Diverting drugs from medically necessary use to illegal resale; or
- **Accepting or offering kickbacks and bribery By Members:**
 - Loaning a VNS Health Health Plans identification card for use by another person;
 - Altering the amount or date of service on a claim form or prescription receipt;
 - Fabricating claims;
 - Reselling items provided by the plan;
 - “Doctor shopping” (seeing several providers to obtain frequent drug prescriptions); or
 - Making excessive trips to the emergency room for narcotics.
- **By Non-Members:**
 - Using a stolen VNS Health Health Plans card to obtain medical services or prescriptions; or
 - Engaging in impermissible sales and marketing practices to steer potential members to or from VNS Health Health Plans.
- **By VNS Health Health Plans Employees:**
 - Creating claims;
 - Delaying assignment of a provider to reduce costs;
 - Failing to provide covered services to reduce costs;
 - Engaging in impermissible sales and marketing practices, such as using unapproved promotional materials, falsifying eligibility information, enrolling individuals without their knowledge or offering inducements to members and providers to join; or
 - Changing member or provider addresses to intercept payments.

II. REPORTING FRAUD, WASTE AND ABUSE

If any VNS Health Health Plans director, officer, manager or staff member, or any other person affiliated with VNS Health Health Plans, suspects FWA, that person is required to report the suspected FWA. A report of suspected FWA may be made directly to the Special Investigations Unit (SIU) via:

- **VNS Health Compliance Hotline:** 1-888-634-1558
- **EthicsPoint Web Portal:** www.vnshealth.ethicspoint.com
- **Mail:** VNS Health Health Plans, Attention: Special Investigations Unit, 220 East 42nd Street, 6th floor, New York, New York 10017

Anyone who reports FWA may do so anonymously. All information received or discovered will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., federal and state authorities, VNS Health Legal Department, Medical Directors and/or Senior Management).

VNS Health Health Plans has a strict policy of not retaliating against, or intimidating, anyone who in good faith reports suspected FWA or another compliance issue.

FWA referrals are received by the SIU through the reporting mechanisms described above, as well as other mechanisms including, but not limited to, verbal or written notification by:

- VNS Health Health Plans directors, officers, managers or other staff members;
- Providers, vendors, consultants, members, caregivers, or First-tier, Downstream and Related Entities (FDRs);
- Members of the public;
- Law enforcement or regulatory agencies;
- Google or other electronic news alerts;
- The Grievance & Appeals Department, which may identify FWA during the investigation of a grievance, complaint, or appeal;
- The Quality Management Department, which may identify FWA during the investigation of a quality of care concern;
- The Provider Network Development Department, which may identify FWA during the investigation of a provider complaint; or
- Other VNS Health Health Plans Departments, such as Medical Management and Pharmacy, involved in authorizing services or monitoring utilization by members.

III. APPLICABLE LAWS, STATUTES AND RESOURCES SUMMARY

Federal

- The **False Claims Act (FCA)**, 31 U.S.C. § 3729–33, as amended, provides for civil actions by the United States government to recover damages and impose civil penalties for false claims for payment. The *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)–(h), authorize private citizens, acting as whistleblowers and designated as relators, to initiate FCA actions to benefit the federal government and to share in any recoveries. Individuals and businesses that “knowingly” submit false claims or fraudulent documentation to the federal government can be liable for damages and civil penalties. The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. The two largest categories of federal funding programs represented in FCA actions are health care and defense industry

fraud. However, any fraudulent request for payment to the federal government or its agents, or to states where the program at issue is partially funded by the federal government, can give rise to an FCA action.

- The **Deficit Reduction Act of 2005** places a greater emphasis on detecting and preventing FWA within the Medicaid program. Specifically, Section 6302 of the DRA, codified at 42 U.S.C. § 1396a(a)(68), requires any entities that pay or receive annual Medicaid payments of \$5 million or more to retain formal policies in combatting FWA for all employees.
- The federal **Anti-Kickback Statute (AKS)**, 42 U.S.C. § 1320a-7, is a criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce (or reward) the referral of federal health care program business. The AKS is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the AKS results in mandatory exclusion from participation in federal health care programs and may also result in a fine of up to \$25,000 and imprisonment for up to five years. Absent a conviction, individuals who violate the AKS may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. The government may also assess civil monetary penalties, which could result in treble damages plus \$50,000 for each violation of the AKS. Although the AKS does not afford a private right of action, the FCA provides a vehicle whereby individuals may bring qui tam actions alleging violations of the AKS. When a private citizen sues on behalf of the federal government and is successful, they receive a percentage of the ultimate recovery for their “whistleblower” efforts.
- The **Stark Law**, 42 U.S.C. § 1395nn, prohibits physician referrals of health services for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that entity. A financial relationship includes ownership, an investment interest, or a compensation arrangement. Referral services may include clinical laboratory tests; physical therapy services; radiology and ultrasound services; radiation therapy services and supplies; DME and supplies; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.
- The **Affordable Care Act** requires providers, Medicare Advantage Plans and Part D (Prescription Drug) Plans to report and return any overpayments within 60 days of discovery.
- The **Health Care Fraud Statute**, 18 U.S.C. § 1347, prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to defraud any health care benefit program; or to obtain (by means of false or fraudulent pretenses,

representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, as amended, provides privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other providers.
- **CMS** requires insurers to maintain a Compliance program that includes measures to detect and prevent FWA.
- The **Health Care Fraud Prevention and Enforcement Action Team (HEAT)** was established by the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to build and strengthen existing programs combatting Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force, which successfully fights fraud.
- Pursuant to the **Exclusion Statute**, 42 U.S.C. § 1320a-7, the HHS **Office of Inspector General (OIG)** must exclude from participation in all federal health care programs any provider or supplier convicted of:
 - Medicare fraud;
 - Patient abuse or neglect;
 - Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service; or
 - Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to impose exclusions on a number of other grounds. Excluded providers cannot participate in federal health care programs for a designated period. An excluded provider may not bill federal health care programs (including, but not limited to, Medicare, Medicaid and State Children's Health Insurance Program (SCHIP)) for services he or she orders or performs. At the end of an exclusion period, an excluded provider must affirmatively seek reinstatement; reinstatement is not automatic.

New York State:

- The **New York State False Claims Act**, N.Y.S. Fin. Law §§ 187–194, allows the Attorney General or any other person to file a lawsuit against a person or a company that obtains or withholds funds or property from the state or local government through false or fraudulent conduct. A person or company found liable under the

act must generally pay treble damages, civil penalties, plus costs and attorneys' fees. Individuals who file suits may be eligible to keep a percentage of the funds they help recover. The state False Claims Act also protects employees from being retaliated against for filing *qui tam* suits against employers who may be engaged in activities or practices that defraud the government of money or property.

- The **Social Services Law**, at § 145-b, makes it a violation to knowingly obtain (or attempt to obtain) payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The state or the Local Social Services District may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to \$10,000 per violation. A penalty of up to \$30,000 per violation may be imposed if repeat violations occur within five years and involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.
- The **Social Services Law**, at § 145-c, states that if any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the needs of the individual or that of his family shall not be taken into account for the purpose of determining his or her needs or that of his family for six months if a first offense, for twelve months if a second offense (or if benefits wrongfully received are at least \$1,000 but not more than \$3,900), for eighteen months if a third offense (or if benefits wrongfully received are in excess of \$3,900), and five years for any subsequent occasion of any such offense.
- The **Penal Law**, at § 176, applies to claims for insurance payments, including Medicaid or other health insurance, and establishes six crimes ranging from Insurance Fraud in the 5th degree (a class A misdemeanor) through Insurance Fraud in the 1st degree (a class B felony). Furthermore, Aggravated Insurance Fraud (committing Insurance Fraud more than once) is a class D felony.
- The **Penal Law**, at § 177, addresses health care providers, including any publicly or privately funded health insurance or managed care plan or contract, who defraud the system. It also includes crimes ranging from Health Care Fraud in the 5th degree (a class A misdemeanor) through Health Care Fraud in the 1st degree (a class B felony).

IV. INVESTIGATING FRAUD, WASTE AND ABUSE

A. Investigation Procedures

The SIU investigates all reports of suspected FWA in accordance with the VNS

Health Health Plans Policies and Procedures on the Special Investigations Unit and Fraud Waste and Abuse, and the VNS Health Corporate Policy on Investigating Compliance Issues and Corrective Action Plans.

The SIU Director reviews all reports of potential FWA (“allegations”) and determines within a reasonable time period following receipt of the report by the SIU not to exceed two (2) weeks whether a case must be initiated.

If, during the timeframes set forth above, the SIU Director determines that an allegation cannot be addressed by the SIU due to lack of resources (including external resources), time or experience (e.g., provider/member collusion cases that require undercover and/or surveillance, or allegations of kickbacks or bribery), the SIU Director will escalate the allegation to the VP, Compliance and Regulatory Affairs, who will determine whether the case is referred to the Qlarant National Benefit Integrity Medicare Drug Integrity Contractor (“MEDIC”), the OMIG or another enforcement agency, as appropriate. In such instances, the referral is documented in the SIU Database, and the case is closed. For referred cases, the SIU promptly responds to any follow up required by MEDIC, the OMIG or any other enforcement agency, and logs its response in the associated case file. If a regulatory or law enforcement agency returns a case to the SIU for investigation, the case is reopened and responded to in accordance with applicable state and federal laws and VNS Health policies and procedures.

If the SIU Director determines that a case must be initiated in response to an allegation, an investigation is commenced within three (3) business days following the opening of a case. Once a case is opened, the SIU Director logs the case in the SIU Database, noting the date the report was received, and establishes a case file (Note: In the case of FWA referrals from the Grievance & Appeals Department, the Grievance & Appeals Department provides the member or member representative with acknowledgment of receipt and notice of referral to the SIU.)

The SIU Director researches the validity of the report, obtains all necessary supporting documentation for the case file and analyzes this documentation. Such activities may include:

- Three-year review, if applicable, of provider or member claims history;
- Review of billing and/or payment history or patterns;
- Review of prescribing/ordering history;
- Provider malpractice, sanctions and exclusions checks;
- Review of medical records;
- Interviews with providers and/or members;
- Review of prior cases involving the provider or member;
- Review of provider and/or member contacts with VNS Health Health Plans;
- Request for assistance from VNS Health Health Plans Operational areas.

Only information that is factual and pertinent to the case is gathered during an investigation.

If an alleged perpetrator of the FWA claim does not forward the requested documentation, the SIU Director will proceed to notify federal and/or state agencies as required (described below) before requesting a refund for the undocumented claims or advising of an offset that will be due or applied, respectively, within 30 days absent extenuating circumstances. In all cases the SIU Director makes best efforts to update any investigation, if possible, every thirty (30) days following receipt of any allegation.

B. Reporting to Federal and State Agencies

The SIU is responsible for notifying applicable federal and state agencies, and law enforcement as appropriate, of suspected FWA. Notified agencies may include OIG, DFS, the OMIG, MEDIC, or the New York State Medicaid Fraud Control Unit (MFCU).

These agencies provide specific forms and/or contact information for notification of suspected FWA. MFCU and the OMIG provide referral forms that can be transmitted by e-mail and toll-free phone and fax numbers; MEDIC supplies a referral form and a fax number; and OIG provides fax and phone numbers as well as an address for written complaints.

If during an investigation the SIU Director determines that potential FWA or other misconduct has occurred, the SIU Director then reports that misconduct to the appropriate agency (MEDIC, DFS, the OMIG, OIG or MFCU) no later than sixty (60) days after the determination that a violation may have occurred.

If potential FWA or other misconduct is discovered at the FDR Level, the SIU forwards the potential FWA or other misconduct to VNS Health Health Plans Counsel for review and will direct the SIU to refer the conduct to the appropriate agency (or agencies) within seven (7) days, so that notified agencies can help identify and address any scams or schemes.

For each case of FWA confirmed by the SIU, the VNS Health Health Plans Compliance Department reports to OMIG the following information:

- The name of the individual or entity that committed the FWA;
- The source that identified the FWA;
- The type of provider, entity or organization that committed the FWA;
- A description of the FWA;
- The approximate range of dollars involved;
- The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and

- Other data/information as prescribed by NYSDOH.

The Compliance Department files an annual report with DOH no later than January 15 of each year, describing VNS Health Health Plans experience, performance, and efficiency in implementing its FWA prevention plan and proposals for improving this plan. The VNS Health Health Plans Compliance Department shall also file an annual Managed Care Provider Investigative report no later the January 30 of each year to the OMIG.

V. PROACTIVE DETECTION OF FRAUD, WASTE AND ABUSE

VNS Health Health Plans devotes significant internal and third-party resources and effort to proactive detection of potential FWA, and—as listed below—has developed key initiatives and processes aimed at proactively detecting patterns and practices of FWA.

- VNS Health Health Plans uses Medicare National Correct Coding Initiative claim coding edits to identify waste and to prevent improper payments.
- The SIU leverages internal and external resources to provide s advanced analytics—specifically, the SAS statistical analysis system—in conjunction with the VNS Health Health Plans Data Warehouse to evaluate outliers and potential FWA patterns.
- The SIU conducts education and awareness training efforts to maximize suspected FWA referrals from directors, officers, managers, other staff members, contractors, agents, providers and FDRs. These efforts are further described in the following section.
- The SIU utilizes Qlarant PLATO, a tool developed by MEDIC, to identify and analyze aberrant trends.

VI. AWARENESS AND EDUCATION

VNS Health Health Plans employs a variety of approaches to promote the awareness and the education of employees and delegated entities about FWA:

- The VNS Health Health Plans website includes an FWA webpage accessible and publicized to directors, officers, managers, other staff members, FDRs, members, providers and the public. The webpage provides information about trends and hot topics in FWA, tips on how to detect FWA and information on reporting. Examples of content include news about recent fraud schemes and advice to members to review their Explanation of Benefits and report any services they should have but

did not receive.

- FDRs that perform operational services on behalf of VNS Health Health Plans, including the pharmacy benefits manager and third-party administrator, attest yearly that they have provided FWA training to their employees and contractors.
- The SIU works with FDRs' special investigation units and audit departments to investigate FWA reports, to share information about individual cases or fraud schemes of common concern and to coordinate responses when potential trends or patterns are identified.
- The VNS Health Health Plans Compliance Department and the SIU perform formal and informal trainings throughout the year. Through a Compliance Awareness Campaign, the Department introduced its enhanced Compliance Program and Code of Conduct and led training and awareness events at all VNS Health locations, with specific content on FWA, including reporting and detection.
- Compliance Awareness Day includes multiple FWA awareness and training communications as well as in-person events.
- The Corporate Compliance Department and the SIU developed an FWA pocket guide.
- The Compliance Department and leadership maintain an open-door policy to communicate compliance concerns, suspected Code of Conduct violations and suspected FWA. This open-door policy is emphasized at every training opportunity.
- The SIU staff attend conferences/events on the latest developments in Compliance and FWA.

VII. COMPLIANCE COMMITTEE AND REPORTING TO BOARD

On a quarterly basis, the SIU reports on FWA and its investigation activities (including trends, patterns, outcomes, corrective actions, and recoupment) to the VNS Health Health Plans Compliance Committee. FWA issues are also reported to the Audit Committee of the VNS Health Board of Directors as well as the VNS Health Health Plans Board of Directors. Such reporting includes the financial impact of claims issues investigated, as well as the estimated savings to VNS Health Health Plans due to changes in billing behavior in response to SIU actions.

The VNS Health Health Plans Fraud Plan is submitted to the Audit Committee of the VNS Health Board of Directors annually for review.

VIII. COLLABORATION WITH LAW ENFORCEMENT AND OTHER HEALTH PLANS

The SIU Director is in regular contact with the OMIG at the investigative level to report suspected FWA and to coordinate on an ongoing basis regarding investigations and audits. The SIU Director attends New York Health Care Fraud Task Force meetings when available to share information on patterns and trends of FWA, and to establish further contacts with law enforcement, as well as other health plans. The SIU coordinates with other health plans' special investigation units to share information on investigations, particularly when a scheme common to the plans' vendors or providers is suspected.

IX. EXCLUSIONS CHECKS AND RELATED MONITORING

VNS Health Health Plans performs monthly checks of all employees against exclusionary lists to ensure that it does not hire or employ persons who have committed FWA or present a program integrity concern. These exclusionary lists include, as appropriate:

- The List of Excluded Individuals and Entities;
- The Excluded Parties System / System for Award Management;
- The Social Security Administration Death Master File;
- The National Plan Provider Enumeration System;
- The OMIG List of Restricted, Terminated or Excluded Individuals or Entities;
- The OIG Most Wanted Fugitives List;
- The Office of Foreign Assets Control – Specially Designated Nationals List;
- The New York State Office of the Professions Misconduct Enforcement System; and
- The New York State Office of Professional Medical Conduct Misconduct Enforcement System
- The CMS Preclusion List

Any checks that raise a potential concern or that involve a question of correct identity are escalated to VNS Health Corporate Compliance.

VNS Health Health Plans also checks new medical and institutional providers and re-enrolled providers, and performs monthly verifications on all participating providers, against excluded provider lists including those listed above. All network providers are required by contract to monitor staff and managers against the exclusionary lists and to report any exclusions to VNS Health Health Plans on a monthly basis. Potential issues identified by provider checks are monitored through reports to the VNS Health Health

Plans Compliance Department and the SIU.

VNS Health Health Plans collects ownership and control disclosure information from managing employees for conflict of interest purposes.

X. FRAUD AND ABUSE RESOURCES

Federal:

• HHS	www.hhs.gov
• CMS	www.cms.gov
• HEAT Task Force	www.stopmedicarefraud.gov
• OIG	www.oig.hhs.gov
• DEA	www.dea.gov
• DOJ	www.justice.gov
• MEDIC	www.healthintegrity.org
• Healthcare Fraud Prevention Partnership	www.hfpp.cms.gov
• FBI	www.fbi.gov

New York State:

• OMIG	www.omig.ny.gov
• MFCU	www.ag.ny.gov/bureau/medicaid-fraud-control-unit
• NYS Attorney General	www.ag.ny.gov
• NYS Physician Profile	www.nydoctorprofile.com
• NYS Professional Misconduct	www.op.nysed.gov/opd
• NYS Department of Health	www.health.ny.gov
• NYS Department of Financial Services	www.dfs.ny.gov

Private organizations:

• NHCAA	www.nhcaa.org
• ACFE	www.acfe.com
• Coalition Against Insurance Fraud	www.insurancefraud.org

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