University of Florida, Pediatric Integrated Care System

Compliance Program

Policy: Ped-I-Care Compliance & Anti-Fraud Plan **Number:** CD-0002

Programs: Title XIX and Title XXI

Effective Date: Title XIX MMA August 1, 2014

Title XXI August 1, 2013

(Revisions are effective 45 days after AHCA approval for Title XIX and after CMS approval for Title XXI.)

(Note: For Title XIX Managed Medical Assistance [MMA], CMS has assumed responsibility for the Anti-Fraud Plan and Compliance Plan).

Approved by:

Title	Name	Signature	Ped-I-Care Approved	CMS Approved	AHCA Approved
Compliance Officer	Mark Hudak, M.D.	Mark L. Hudak M.D.	8/30/2010, 9/19/2011, 3/19/2012, 9/6/2013, 3/21/2014, 9/25/2015, 3/17/2016	5/9/2011	5/9/2011
Revised	8/2/2010, 12/15/2010, 7/1/2011, 9/30/2011, 3/13/2012, 11/23/2012, 1/24/2013, 2/26/2013, 8/30/2013, 12/20/2013, 7/30/2014, 4/24/2015, 8/16/2015, 3/11/2016				

Responsible Party: Compliance Officer, Compliance Director, Compliance Department, Compliance Committee, Contracting Department, Administrative Assistant, All Ped-I-Care Departments and staff, Children's Medical Services (CMS), MED3000

Ped-I-Care
Compliance & Anti-Fraud Plan

Compliance Officer, Mark Hudak, M.D., is responsible for ensuring adherence to this plan. He has unrestricted access to Ped-I-Care's Advisory Board, the Chair of University of Florida's Department of Pediatrics, and the Dean of University of Florida's College of Medicine. His contact information is:

Mark Hudak, M.D.
Ped-I-Care Compliance Officer
Professor and Associate Chairman of Pediatrics
University of Florida College of Medicine - Jacksonville
655 W. 8th Street, Jacksonville, FL 32209
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Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
I. Policy			
A. Maintain Compliance policies that are designed to prevent, detect, and report known or suspected fraud and abuse activities	1. Create, review, and update Compliance policies 2. Ensure policies, procedures, and standards of conduct clearly articulate Ped-I-Care's commitment to comply with all applicable federal and state standards 3. Review and adopt Ped-I-Care's Compliance policies	Compliance Officer & Compliance Director Compliance Committee	Annually & as needed Biennially
II. Fraud and Abuse Training and Education	(See Attachment IV)		
A. Ped-I-Care Staff Training	1. Train all Ped-I-Care staff 2. Conduct necessary training as needs are identified 3. Maintain record of all trainings	Compliance Department	Within 30 days of hire & Annually As needed Ongoing
B. Ensure that details are provided to educate providers	1. Implement an online fraud and abuse training module 2. Provide details regarding the availability of the training module on Ped-I-Care's website and in the Provider Manuals 3. Review and update the information available on the Compliance page of Ped-I-	Compliance Director Compliance Department Compliance Program Manager	September 2011 Ongoing Annually

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	Care's website		
C. Delegation Training (MED3000)	1. Review MED3000's Materials 2. Ensure annual staff education	Each department responsible for daily activities oversight	Annually
D. Compliance Department Auditing Staff Training	1. Auditors will obtain CPMA or CEMC certification 2. Auditors will obtain AAPC continuing education units related to medical chart auditing	Compliance Auditors Compliance Auditors	Within 2 years of hire Ongoing
E. Keep abreast of current fraud and abuse topics, issues, and activities throughout the state of Florida	1. Attend AHCA's Quarterly Fraud and Abuse Meetings for Title XIX and CMS Meetings for Title XXI 2. Respond to AHCA's and CMS' requests for information 3. Provide suggestions and feedback on ways to improve communication and the detection of fraud and abuse 4. Review AHCA Final Order alert emails 5. Send out educational email alerts to staff of fraud and abuse cases throughout the country	Compliance Director and/or Audit Manager Compliance Department if fraud and abuse related; Applicable Department when not related to fraud and abuse Compliance Department Compliance Department Compliance Auditors	Quarterly As needed Ongoing Ongoing Monthly
III. Auditing and Monitoring			
A. Ensure that Ped-I-Care staff have received Fraud and Abuse Training	1. Send the Compliance Department a quarterly report of the training compliance rate 2. Follow-up with any Ped-I-Care staff that haven't taken the training as required	Compliance Administrative Assistant Compliance Administrative Assistant	Quarterly As needed
B. Maintain a Fraud and Abuse Hotline	1. Monitor the dedicated, confidential hotline for reporting suspected fraud,	Compliance Department	Ongoing

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	waste, or abuse 2. Investigate allegations in a timely manner		
C. Ensure delegated entities provide required reports as outlined in contract and within policies	1. Audit for receipt of reports 2. Analyze information relating to each department 3. Report any issues or concerns to the Executive Director 4. Attempt to resolve any issues or concerns with the delegated entity 5. Report any ongoing issues or concerns that are not resolved in a timely manner to the Compliance Officer and Compliance Director 6. Report findings to Compliance Committee	All Departments Respective Departments All Departments Executive Director Executive Director Compliance Officer	Monthly Monthly As identified As needed As identified Biannually as needed
D. Ensure provider compliance with billing and documentation	1. Notify the Compliance Department of any concerns 2. Conduct risk assessment 3. Conduct audits of provider billing practices 4. Perform audits of medical records 5. Send evaluation results to provider 6. Develop and perform or direct provider to the needed training 7. Create Corrective Action Plans (CAP) when appropriate 8. Evaluate adherence to and effectiveness of CAP 9. Document findings and outcomes in Compliance tracking database	CMS, All Departments, and MED3000 Compliance Department	Ongoing
E. Ensure compliance of each Ped-I-Care department/staff with policies, procedures, and all contractual obligations	1. Review all policies, procedures, contracts, contract amendments, and applicable statues and regulations 2. Each department is monitored by the department supervisor for compliance 3. Conduct internal audits to ensure compliance with contract requirements, policies, and procedures 4. Document audit results	All Departments Department Supervisor Department Supervisor Department	Ongoing Ongoing Quarterly Quarterly

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
		Supervisor	
	5. Analyze areas needing improvement	Department Supervisor	Ongoing
	6. Review adverse findings with the Executive Director and the Compliance Director	Department Supervisor	As identified
	7. Create CAP to address deficiencies within 14 days of detection	Department Supervisor	As needed
	8. Send CAP to the Executive Director and Compliance Director for review and comment	Department Supervisor	Within 14 days of detecting the need for a CAP
	9. Implement the CAP after approval	Department Supervisor	Within 1 week of approval
	10. Evaluate adherence to and effectiveness of CAP	Department Supervisor	At least monthly
	11. Report completion of CAP items to the Compliance Department	Department Supervisor	Upon completion
	12. Develop and perform training needs assessment for staff	Department Supervisor	When issues are identified & Annually
	13. Perform any necessary training to staff	Department Supervisor	Ongoing
	14. Document details of training efforts	Department Supervisor	When performed
	15. Report training efforts to the Compliance Department	Department Supervisor	Quarterly
	16. Document findings and outcomes in Compliance tracking database	Compliance Department	Ongoing
F. Investigate potential compliance issues reported by email, regular mail, fax, phone, in person, or through any other means	1. Research issue 2. Perform audit if needed and/or refer issue to appropriate department/area to address 3. Analyze areas needing improvement 4. Perform any necessary training 5. Create CAP to address deficiencies 6. Evaluate adherence to and effectiveness of CAP 7. Document findings and outcomes in Compliance tracking database	Compliance Department	Ongoing
G. Ensure no Ped-I-Care staff or providers are	1. Compare newly recruited providers to the LEIE and SAM	Contracting Department	Prior to contracting

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
on the List of Excluded Individuals and Entities (LEIE) or System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS])	2. Compare new Ped-I-Care staff to the LEIE and SAM	UF Human Resources Department	Prior to hire
	3. Compare existing providers to the LEIE and SAM	Compliance Administrative Assistant	Monthly
	4. Investigate possible matches 5. Notify the Contracting and Compliance Departments of any matches	Compliance Administrative Assistant	When identified
	6. If matches are identified, contact the legal department	Contracting Department	When identified
	7. Remove the identified individual from any work or service that is federally funded	Contracting Department	Within 5 calendar days of notification
	8. Notify the Compliance Department of any actions and outcomes	Contracting Department	Within 1 week
H. Review AHCA Final Orders	1. Compare the providers listed as suspensions or terminations in the AHCA Final Orders on AHCA's website to the provider network	Compliance Administrative Assistant	Monthly
	2. Notify the Contracting and Compliance Departments of any provider matches	Compliance Administrative Assistant	As identified
	3. Take appropriate action to exclude provider and facility matches from participation in the network	Contracting Department	Within 5 calendar days of detection
I. Review Termination Notices from AHCA	1. Compare the providers listed in the AHCA Termination Notices to the provider network a. Prior to contracting with a provider b. As notices are sent by AHCA	Contracting Department prior to contracting and Compliance Administrative Assistant as notices are sent	Prior to contracting with a provider and within 3 business days of receiving the notice
	2. Notify the Contracting and Compliance Departments of any provider matches		When identified
	3. Take appropriate action to exclude provider matches from participation in the network	Contracting Department	Within 5 calendar days
J. Develop Compliance Database	1. Create database for reporting and tracking of Compliance activities	Compliance Administrative Assistant	February 2012
	2. Test database	Compliance Department	March 2012

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	3. Make adjustments as needed 4. Document all Compliance findings and outcomes in tracking database	Compliance Administrative Assistant Compliance Department	Within 1 week of identification Ongoing
K. Verify with members that services billed by providers were received	1. Determine method to verify provided services with members 2. Discuss billed services with members during contact and eligibility redetermination 3. Evaluate effectiveness of notification method and, if needed, adjust notification method accordingly 4. Investigate allegations of services not being provided or billed incorrectly	CMS CMS Nurse Care Coordinators CMS Central Office Compliance Department	December 2013 Ongoing April 2014, then quarterly Ongoing
IV. Reporting			
A. For Title XIX notify AHCA's OIG, MPI and for Title XXI notify CMS Contract Manager of suspected or confirmed cases of fraud and/or abuse	1. Submit an online complaint form 2. Submit investigation information on the quarterly report	Compliance Department	Within 15 calendar days of detection Quarterly
B. For Title XIX notify the DHHS OIG and Ped-I-Care's Compliance Department and for Title XXI notify the CMS Contract Manager and Ped-I-Care's Compliance Department of individuals/facilities who have met the conditions giving rise to mandatory or permissive exclusions	1. Monitor and maintain records of the following: a. Actions taken to limit the ability of a provider to participate in the network b. Providers convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs c. Providers denied initial entry into the network for program integrity-related reasons d. Individuals with ownership	Children's Medical Services Central Office (CMS CO) Provider Approval (Credentialing) Unit	Ongoing

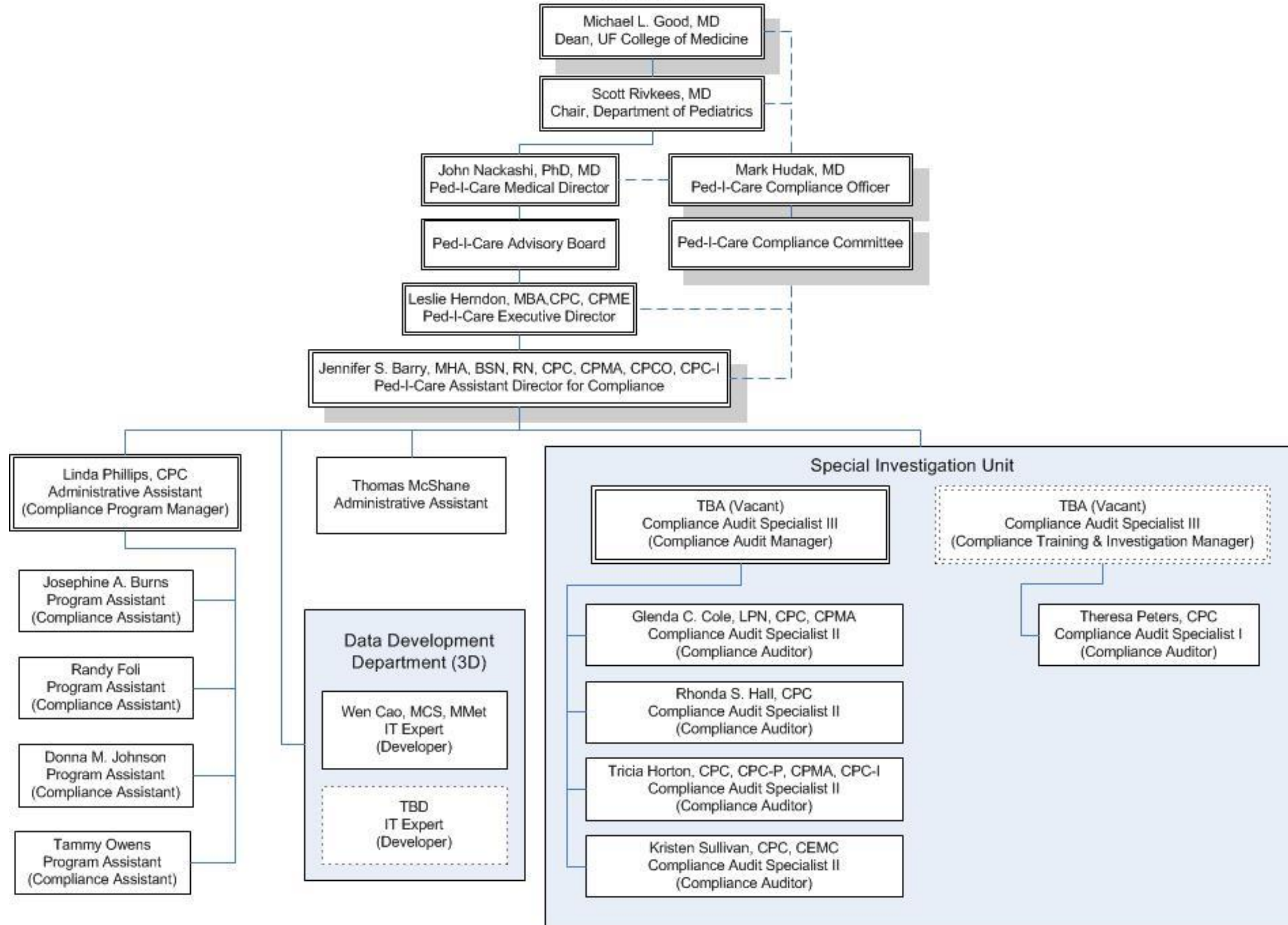
Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	or control interest in a network provider, or subcontractor, or is an agent or managing employee of a network provider or subcontractor		
	2. For Title XIX send notification to the DHHS OIG as instructed by AHCA and Ped-I-Care's Compliance Department and for Title XXI notify the CMS Contract Manager and Ped-I-Care's Compliance Department of any findings including the actions taken regarding the participation of the provider/facility with the network	CMS Central Office	Within 10 business days of detection
C. Notify the Compliance Committee	1. Provide a summary of providers excluded from participation in the network to the Compliance Director	Network Manager	No less than 3 weeks prior to Compliance Committee Meetings
	2. Provide a summary of investigations, activities, and the providers excluded from participation in the network to the Compliance Officer	Compliance Director	2 weeks prior to Compliance Committee Meetings
	3. Present a summary of investigations, activities, providers excluded from participation in the network, and any required details to the committee	Compliance Officer	Biannually during meetings
D. Review the results of investigations of fraud, abuse, or overpayment conducted during the previous year (See Attachment II)	1. Create a report 2. Submit it to the Compliance Auditors for review	Compliance Assistant	Annually by July 15th
	3. Review the results and submit the final report to the Compliance Director	Compliance Auditors	Annually by July 29th
	4. Review the results and send to the Compliance Officer	Compliance Director	Annually by August 15th
	5. Review the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year and provide feedback to the Compliance Director	Compliance Officer	Annually by August 20th

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	6. Submit the Title XIX and Title XXI reports to the CMS Contract Manager for review	Compliance Director	Annually in August
	7. For Title XIX, submit the report and attestation to the AHCA MPI SFTP site	CMS Contract Manager	Annually by September 1st
E. Review Compliance & Anti-Fraud Plan	1. Update the plan after meeting with the Compliance Director	Compliance Assistant	Annually in January
	2. Submit it to the Compliance Auditors for review	Compliance Assistant	
	3. Review and submit the final plan to the Compliance Director	Compliance Auditors	
	4. Review the plan and send to the Compliance Officer	Compliance Director	Annually in February
	5. Review the plan and provide feedback to the Compliance Director	Compliance Officer	Annually by March 1st
	6. Present the plan to the Compliance Committee for approval	Compliance Officer	Annually
	7. Submit the plan to the CMS Contract Manager for review	Compliance Director	August Annually
	8. Submit the plan for Title XIX to the AHCA MPI SFTP site	CMS Contract Manager	Annually by September 1st
V. Staffing			
A. Hire an Auditor	1. Interview and hire 2. Educate and train	Compliance Director & Compliance Audit Manager	January 2010, November 2013 June 2010, December 2013
B. Hire an Administrative Assistant	1. Interview and hire 2. Educate and train	Compliance Director	July 2010, November 2013 October 2010, December 2013
C. Maintain an organizational chart outlining the organizational arrangement of the personnel responsible for the investigation and reporting of possible overpayment, abuse, or fraud	1. Create organizational chart 2. Review and update the organizational chart (See Attachment I)	Compliance Assistant	July 2010 Annually
D. Evaluate staffing needs	1. Review workload and determine the type and amount of staff needed to effectively	Compliance Department	Annually

Objectives	Action Steps Compliance Policies and/or Activities	Responsible Department or Person	Scheduled Completion Date
	operate the Compliance Department's needs 2. Discuss findings with Compliance Officer	Compliance Director	Annually
E. Hire new staff as needed	1. Interview and hire 2. Ensure education and training occurs with an experienced staff member in the Compliance Department	Compliance Director	As needed

Acronyms:

AAPC – American Academy of Professional Coders
AHCA – Agency for Health Care Administration
CAP – Corrective Action Plan
CMS – Department of Health, Children's Medical Services
CPC – Certified Professional Coder
CPMA – Certified Professional Medical Auditor
DHHS – Department of Health and Human Services
EPLS – Excluded Parties List System
LEIE – List of Excluded Parties and Entities
MED3000 – CMS and Ped-I-Care's Third Party Administrator
MPI – Medicaid Program Integrity
OIG – Office of the Inspector General
SAM – System for Award Management


Ped-I-Care Compliance Department
3/11/2016
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Dean, UF College of Medicine
Scott Rivkees, MD
Chair, Department of Pediatrics
John Nackashi, PhD, MD
Ped-I-Care Medical Director
Mark Hudak, MD
Ped-I-Care Compliance Officer
Ped-I-Care Advisory Board
Ped-I-Care Compliance Committee
Leslie Herndon, MBA,CPC, CPME
Ped-I-Care Executive Director
Jennifer S. Barry, MHA, BSN, RN, CPC, CPMA, CPCO, CPC-I
Ped-I-Care Assistant Director for Compliance
Linda Phillips, CPC
Administrative Assistant
(Compliance Program Manager)
Thomas McShane
Administrative Assistant
Josephine A. Burns
Program Assistant
(Compliance Assistant)
Randy Foli
Program Assistant
(Compliance Assistant)
Donna M. Johnson
Program Assistant
(Compliance Assistant)
Tammy Owens
Program Assistant
(Compliance Assistant)
Data Development
Department (3D)
Wen Cao, MCS, MMet
IT Expert
(Developer)
TBD
IT Expert
(Developer)
Special Investigation Unit
TBA (Vacant)
Compliance Audit Specialist III
(Compliance Audit Manager)
TBA (Vacant)
Compliance Audit Specialist III
(Compliance Training & Investigation Manager)
Glenda C. Cole, LPN, CPC, CPMA
Compliance Audit Specialist II
(Compliance Auditor)
Rhonda S. Hall, CPC
Compliance Audit Specialist II
(Compliance Auditor)
Tricia Horton, CPC, CPC-P, CPMA, CPC-I
Compliance Audit Specialist II
(Compliance Auditor)
Kristen Sullivan, CPC, CEMC
Compliance Audit Specialist II
(Compliance Auditor)
Theresa Peters, CPC
Compliance Audit Specialist I
(Compliance Auditor)

Attachment II – Investigation Summary Annual Report

This report is updated and reported annually by September 1st.

July 1, 2014 – June 30, 2015

CMS – Annual Fraud and Abuse Activity Report for Title XXI

# of Referrals to CMS	Total Overpayments Identified for Recovery	Total Overpayments Recovered	Total Dollars Identified as Lost to Fraud & Abuse	Total Dollars Lost to Fraud & Abuse that were Recovered	Notes
86	$251.44	$0	$0	$0	Due to training new staff, many of the investigations are still in progress with overpayment amounts to be determined.

MPI – Annual Fraud and Abuse Activity Report for Title XIX, Medicaid Managed Medical Assistance (MMA)

AHCA Contract Number	Managed Care Plan Identifier	Managed Care Plan Medicaid Provider Number	Total Overpayments Identified	Total Overpayments Recovered	Total Dollars Lost to Fraud and Abuse	Total Dollars Lost to Fraud and Abuse That Were Recovered	Total Number of Referrals	Note
FP031	CMS	011808601	$0.00	$0.00	$0.00	$0.00	7	Due to training new staff, many of the investigations are still in progress with overpayment amounts to be determined.
FP031	CMS	011808602	$0.00	$0.00	$0.00	$0.00	2	
FP031	CMS	011808603	$133.04	$0.00	$0.00	$0.00	51	
FP031	CMS	011808604	$153.94	$0.00	$0.00	$0.00	17	
FP031	CMS	011808605	$0.00	$0.00	$0.00	$0.00	2	
FP031	CMS	011808606	$0.00	$0.00	$0.00	$0.00	6	
FP031	CMS	011808607	$0.00	$0.00	$0.00	$0.00	5	
FP031	**CMS**	**011808601-7**	**$286.98**	**$0.00**	**$0.00**	**$0.00**	**90**	

Attachment II – Investigation Summary Annual Report

MPI – Annual Fraud and Abuse Activity Report for Title XIX, Medicaid Reform

AHCA Contract Number	Health Plan Identifier	Health Plan Medicaid Provider #	# of Referrals to MPI	Total Overpayments Identified for Recovery	Total Overpayments Recovered	Total Dollars Identified as Lost to Fraud & Abuse	Total Dollars Lost to Fraud & Abuse that were Recovered	Notes
FA909	CMD	015063102	5	$2,969.82	We cannot determine the amount of overpayments recovered because we did not pay the claims and do not have a way to verify that practices void claims as instructed.	$0	$0	We are no longer performing Medicaid Reform audits.

The Agency for Health Care Administration (AHCA) and Children's Medical Services (CMS) require that we have a compliance program. This program is dedicated to the prevention and detection of fraud and abuse through a collaboration effort. Appropriate enforcement measures based on compliance findings will be undertaken after consultation with or notification of AHCA and CMS. Medicaid provider and member fraud can manifest in multiple ways and we solicit and anticipate the cooperation of diligent providers and members to uncover and report this type of activity. Our goal is to prevent, detect, and correct any violations. Ped-I-Care actively attempts to prevent and identify suspected incidents of fraud and billing abuse. All activities seen as fraud and/or abuse will be reported to the Ped-I-Care Compliance Department for investigation and follow-up. Providers must comply with all aspects of Ped-I-Care's Compliance Program and its fraud and abuse plan/requirements.

Compliance Activities and Investigations

Ped-I-Care proactively conducts both prospective and retrospective searches and analyses to seek potential fraud and abuse using resources such as (but not limited to) claims, utilization management, quality management, grievance/appeals, complaints, and random chart audits. Pursuant to Medicaid regulations, in the event of suspected fraud and/or abuse, chart audits may be conducted without prior notice. Findings suggestive of fraud and abuse will be reported to the Office of Medicaid Program Integrity as appropriate and needed. Note that any resolution to audit findings and investigations in no way binds nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter.

Provider Training

Our Compliance Program trains providers and their staff members and investigates fraud and abuse. Providers and practices are responsible for ensuring they and their staff are adequately trained regarding fraud and abuse. Ped-I-Care's online training tutorial is available at http://pedicare.peds.ufl.edu/compliance/index.html. Completion of Ped-I-Care's online training is not mandatory but is recommended and may be utilized as a resource for practices to train providers and staff.

Excluded Provider Notification

Ped-I-Care routinely monitors the Health and Human Services (HHS) Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS]), Medicaid termination and ineligible lists, Florida Department of Health (DOH) license notifications, and AHCA Final Orders to identify individuals excluded from participation in Florida Medicaid, and therefore Ped-I-Care. Providers, facilities, and groups must notify Ped-I-Care immediately if they become ineligible to participate in federally funded programs or receive federal money.

Reporting Fraud and Abuse

Confidentiality will be maintained for the suspect person or entity and the person reporting, and all rights afforded to both providers and members will be reserved and enforced during the investigation process.

You may report suspected cases of fraud and abuse anonymously. You may also report confidentially without fear of retaliation. You may report in one or more of the following ways:

- By phone to any of the following hotlines:

    1. The Ped-I-Care Compliance Fraud & Abuse Hotline toll free at 866-787-4557 or locally at 352-627-9300
    2. The Florida Medicaid Fraud and Abuse Hotline at 888-419-3456
    3. The Department of Health and Human Services Office of the Inspector General (OIG) at 800-447-8477
    4. The Florida Attorney General's Hotline for Reporting Medicaid Fraud at 866-966-7226

- Online by filling out the Medicaid Fraud and Abuse Complaint Form (to report suspected fraud and abuse in the Florida Medicaid system) at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

- By emailing information to pedicarecd@peds.ufl.edu, faxing it to 352-294-8080, or mailing it to:
  Ped-I-Care Compliance Department
  1699 SW 16th Avenue, Room 3132
  Gainesville, FL 32608

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Attachment IV – Fraud and Abuse Training

As stated in the CD-0005 Compliance and Abuse Training Policy:

1. Ped-I-Care's self-study Fraud and Abuse training is maintained and accessible year round at http://www.pedicare.peds.ufl.edu/compliance/index.html.

2. All employees must complete Fraud and Abuse Training program within the first thirty (30) days following their date of hire and annually thereafter.

3. The Compliance Training consists of:

   a. Elements of the Ped-I-Care Compliance Program including but not limited to:

      i. Federal Deficit Reduction Act
      ii. False Claims Act(s)
      iii. Stark Laws
      iv. Anti-kickback Laws
      v. Compliance auditing and monitoring (internal as well as external)
      vi. Compliance Reporting Hotline and toll-free state telephone numbers for reporting fraud and abuse

   b. Fraud and Abuse Responsibilities and Penalties

   c. Ped-I-Care employee, provider, and member reporting obligations, protections, and non-retaliation/non-retribution for reporting

2. The Compliance Department maintains a log of employee training.

3. Practices/providers are responsible for ensuring their staff is trained regarding Fraud and Abuse and any applicable rules and regulations. Completion of Ped-I-Care's online training is not mandatory but is recommended and may be utilized as a resource for practices to train providers and staff.

   a. Ped-I-Care's online training is available for practices/providers to educate staff.

   b. Ped-I-Care sends practices a pdf version of the online training when requested. The practice documents any employee training not conducted online.

4. Members are educated about fraud and abuse through the Member Handbook, newsletters, during calls to Ped-I-Care's Member Services Department when appropriate, and on Ped-I-Care's website.

Attachment V – Disciplinary Guidelines

Ped-I-Care enforces standards through well-publicized disciplinary guidelines. The disciplinary process for Ped-I-Care employees is available online at http://hr.ufl.edu/emp_relations/disciplinary.asp. All provider contracts contain a clause regarding Ped-I-Care's right to terminate or suspend the contract if the provider has been terminated or suspended from participation in AHCA or the CMS Program, or has been charged or convicted of Medicare or Medicaid fraud, or other professional misconduct or criminal conduct, or if the provider is in violation of any provision of the contract.

Ped-I-Care's Fraud and Abuse training details the Anti-Kickback Statue, Stark Law, and False Claims Act violation penalties. The training also lists the following consequences for committing Medicaid fraud:

1. Exclusion from participating in Medicare, Medicaid, or any other federal or state health care programs
2. Exclusion from working in any facility receiving federal health care funds
3. Loss of License (LPNs, RNs, MDs, etc.)
4. Arrest and prosecution
5. Criminal penalties of fines and jail or prison time

As stated in the CD-0003 Program Integrity Plan Policy:

(5) Disciplinary actions are in accordance with UF's Human Resources and contracting policies, procedures, and approval (credentialing)/re-approval (re-credentialing) processes.

i. Employees and business partners are appropriately informed of their violations and discipline which may include but is not limited to termination.

ii. Documentation of violations and disciplinary actions are retained.

iii. Periodic review is used to promote consistency and effectiveness as part of the Compliance Program.

Attachment VI – Compliance Committee Members

Mark L. Hudak, MD (chair)
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Attachment VII – Compliance Department Staff

Compliance Officer

This position is responsible for the Compliance Program that will identify, report, and prevent fraud and abuse among Ped-I-Care providers and members. Ped-I-Care is a health plan for children with special health care needs. This position is responsible for overseeing an effective and well-publicized disclosure program to provide guidance and receive complaints about potential Compliance Program violations and fraud and abuse without fear of retaliation. This position ensures the plan's management, employees, and contracted physicians are in compliance with the fraud and abuse rules and regulations of regulatory agencies, that policies and procedures are followed, and that behavior in the organization is consistent with the University of Florida's Standards of Conduct.

The Compliance Department exists as a channel of communication to receive and direct compliance issues to appropriate resources for investigation and resolution, and as a final internal resource with which concerned parties may communicate after other formal channels and resources have been exhausted.

The Compliance Officer monitors and reports results of the compliance/ethics efforts of Ped-I-Care and provides guidance to the senior management team on matters relating to compliance. The Compliance Officer, together with the Compliance Committee, is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.

Compliance Director

This position is responsible for implementing and overseeing a Compliance Program that will identify, report, and prevent fraud and abuse among Ped-I-Care employees, providers, and members. Ped-I-Care is a health plan for children with special health care needs and their well siblings. This position is responsible for implementing effective education and training programs regarding the Compliance Program as well as establishing procedures for the monitoring and detection of potential fraud and abuse. Once there is evidence that there may be fraud and/or abuse, Title XIX cases are reported to the Medicaid Office of Program Integrity and Title XXI related cases are reported to Children's Medical Services for further investigation and potential prosecution. This position is responsible for maintaining an effective and well-publicized disclosure program to provide guidance and receive complaints about potential Compliance Program violations and fraud and abuse without fear of retaliation. This position must implement and maintain effective auditing and monitoring systems and protocols to evaluate providers' and members' compliance with laws, regulations, and other federal and state health care program requirements and Compliance Program standards. Prevention of Compliance Program violations and maintaining the efficacy of the Compliance Program is a must. This position is under the direct supervision of and reports to the Executive Director. This position keeps the Compliance Officer abreast of concerns.

Compliance Program Manager (Administrative Assistant)

This position functions as manager of administrative functions for the Compliance Program and is responsible for supervising staff that schedule chart audit reviews; preparing all visit and

training materials for the Compliance Department; entering and maintaining accurate data regarding chart reviews and training; following up and documenting areas of concern; organizing, preparing for, attending, recording, and distributing information for compliance meetings and reviews; and preparing data for reports and audits. This position is responsible for general administrative support of the Compliance Director.

This position is responsible for working with the Ped-I-Care Compliance Officer, Director, and Auditors to assist in the development and implementation of a Compliance Plan as required by the Department of Health (DOH) and Agency for Health Care Administration (AHCA). Under the program, this position is responsible for monitoring weekly and monthly reports on all claims submitted to MED3000 (our third party administrator) by our contracted and non-contracted providers to identify and prevent Medicaid fraud and abuse. On-site chart audits and training are conducted based on the results of these reviews. Random chart audits are also conducted to identify potential fraud and abuse. This position is responsible for monitoring the Ped-I-Care fraud and abuse hotline and handling any complaints that may be registered in this fashion. This position assists with reports and the gathering of information. This position provides support to the Compliance Department, maintains the Compliance data base, and provides data for reporting when needed. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Data Manager (Administrative Assistant)

This position functions as an Administrative Assistant for the Compliance Department and is responsible for analyzing, entering, and maintaining accurate data in Compliance databases; creating forms; creating and reviewing reports; ensuring the fraud and abuse training module is updated and data is accurate; maintaining training logs; and other administrative duties. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Training and Investigation Manager (Compliance Audit Specialist III)

This position is responsible for working with the Ped-I-Care Compliance Department, Compliance Officer, and Compliance Director to develop and implement a coding, fraud, and billing abuse training as required by the Department of Health (DOH) and Agency for Health Care Administration (AHCA). This position is responsible for ensuring new staff receive fraud and abuse training as required, for provider education as required and when the need is evident, and for continued monitoring to ensure problems are corrected. This position is responsible for monitoring the Ped-I-Care fraud and abuse hotline and handling any complaints that may be registered in this fashion. This position requires detailed knowledge of all CMS/DOH, AHCA, and Ped-I-Care contracts, and correct health care coding and billing procedures and practices, Centers for Medicare and Medicaid Services guidelines for addressing fraud and abuse, Medicaid billing rules and regulations and data acquisition and reporting. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Audit Manager (Compliance Audit Specialist III)

This position is responsible for working with the Ped-I-Care Compliance Department, Compliance Officer, and Compliance Director to develop and implement a Compliance Plan as

required by the Department of Health (DOH) and Agency for Health Care Administration (AHCA). This position trains and oversees the fraud investigation unit staff. On-site chart audits are conducted based on the results of claims data review and/or complaints received regarding potential fraud and/or abuse. Random chart audits are also conducted to identify potential fraud and abuse.

If a provider continues to exhibit aberrant billing and coding practices, this position will report this to the Compliance Director for possible reporting to the Medicaid Office of Program Integrity (MPI) in the Inspector General's Office for Title XIX and to Children's Medical Services (CMS) for Title XXI. This position requires detailed knowledge of all CMS/DOH, AHCA, and Ped-I-Care contracts, and correct health care coding and billing procedures and practices, Centers for Medicare and Medicaid Services guidelines for addressing fraud and abuse, Medicaid billing rules and regulations and data acquisition and reporting. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Auditors (Compliance Audit Specialists)

This position is responsible for working with the Ped-I-Care Compliance Department, Compliance Officer, Compliance Director, Compliance Audit Specialist III, and is responsible for conducting compliance audits of Ped-I-Care's contracted providers to ensure data integrity, compliance with federal and state regulations pertaining to, but not limited to provider billing services. This position works closely with all members of Ped-I-Care staff/departments and ensures effective communication with providers, member parents/guardians, ICS Medical Directors, CMS Nurse Care Coordinators (NCCs), the TPA, CMS, AHCA, Office of the Inspector General (OIG), Medicaid Office of Program Integrity (MPI), and anyone involved in billing and member care. This position is responsible for developing corrective action plans (CAPs) when compliance investigations detect deficiencies. This position follows up on concerns/complaints. This position keeps the appropriate parties notified of any issues, changes, or concerns that arise and documents all aspects of compliance issues. This position is under the direct supervision of and reports to the Compliance Audit Manager.

Compliance Program Assistants

This position functions as program support to the Compliance Program and is responsible for scheduling chart audit reviews. This position prepares and organizes needed information for the Assistant Director for Compliance, Officer, and Auditors. This position is responsible for preparing all visit and training materials for the Compliance Department; entering and maintaining accurate data regarding chart reviews and training; following up and documenting areas of concern; organizing, preparing for, attending, recording, and distributing information for compliance meetings and reviews; preparing data for reports and audits; and comparing Ped-I-Care's staff and provider networks to termination and exclusion lists. This position is responsible for monitoring weekly and monthly reports on all claims submitted to MED3000 (our third party administrator) by our contracted and non-contracted providers to identify and prevent Medicaid fraud and abuse. On-site chart audits and training are conducted based on the results of these reviews. This position gives support to the Compliance Department, maintains the Compliance data base, and provides data for reporting when needed. This position is under the direct supervision of and reports to the Compliance Program Manager.

Information Technology (IT) Experts

This position functions as technical support for the Compliance Program and is responsible for developing and maintaining systems, databases, interfaces, auditing forms, reporting, the web portal, and the training website. This position ensures new and existing employees and providers have access to Ped-I-Care's online fraud and abuse training module. This position is under the direct supervision of and reports to the Compliance Director.

Fraud Definition: An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

Examples of Provider Fraud:

- Billing for an office visit when there was none, or adding additional family members' names to bills
- Billing for services that were not provided, e.g., a chest x-ray that was not taken
- Billing for more time than was actually provided, i.e., counseling, anesthesia, etc.
- Requiring the recipient to return to the office for more visits when another appointment is not necessary
- Ordering unnecessary x-rays, blood work, etc.
- Upcoding (billing for a more involved or time-consuming service than was actually provided), e.g., providing a simple office visit and billing for a comprehensive visit
- Billing for transportation that is not medically necessary or is not related to health care
- Billing for services that are not medically necessary, or are not for a medical purpose
- Accepting payment from another provider, including sharing in the reimbursement paid by the Medicaid program, as a result of referring a patient to the other provider
- Duplicate billing such as billing Medicaid and another payer and/or the recipient for the same service
- Having an unlicensed person perform services that only a licensed professional should render, and billing as if the professional provided the service
- Unbundling codes (billing separately for each component of the code) which results in increased payment, when one comprehensive code includes all related services at a lesser reimbursement rate. This also includes incidental procedures that are typically done as part of a larger procedure and, because they take little extra effort, are not usually reimbursed separately. Examples include laboratory blood test panels, surgical procedures, etc.

Examples of Member Fraud:

- Intentionally underreporting income, assets, resources etc.
- Loaning a Medicaid Identification card to another person
- Using multiple ID cards and/or Medicaid numbers
- Forging or altering a prescription or fiscal order
- Intentionally receiving duplicative, excessive, contraindicated or conflicting health care services or supplies
- Re-selling items provided by the Medicaid program
- Misrepresentation of a medical condition

Abuse Definition: Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet

professionally recognized standards for health care, or recipient practices that result in unnecessary cost to the Medicaid program.

Examples of Provider Abuse:

- Over utilization of health care services
- Provider billing irregularities
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Improper billing practices
- Billing for services not provided
- Inaccurate coding
- Misrepresentation of professional credentials/licensing/status of licensure

Examples of Member Abuse:

- Residing out-of-state
- Tampering with prescriptions
- Drug seeking behaviors
- Failure to report third party liability

Overpayment Definition: Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Examples of Overpayment:

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits.
- Payment for noncovered items and services, including medically unnecessary services or custodial care furnished to a member.
- Payment based on a charge that exceeds the reasonable charge.
- Duplicate processing of charges/claims.
- Payment to a physician on a non-assigned claim or to a member on an assigned claim. (Payment made to wrong payee.)
- Primary payment for items or services for which another entity is the primary payer.
- Payment for items or services rendered during a period of non-entitlement.

Attachment IX – Internal Controls and Processes

All personnel and departments are responsible for notifying the Compliance Department of potential and suspected fraud and/or abuse immediately. Identification may occur through the daily operations and processes of each department and/or interactions and communication with other departments, companies, providers, groups, members, etc. Each personnel in every department is responsible for monitoring information including but not limited to medical records, notes, letters, calls, emails, faxes, and any other information or communication source. The Compliance Department determines how to proceed regarding any reports and suspicions.

Referrals may be generated by any of, but are not limited to, the following detection methods:

1. Calls from members, providers, provider staff, AHCA, CMS, Ped-I-Care employees, and/or the general public.
2. Suspicions identified by personnel who review or process claims.
3. Suspicions identified by staff that communicate with or visit providers.
4. Suspicions identified by staff that reviews referral and authorization requests.
5. Information received from members.
6. Referrals from our third party administrator.
7. Information obtained in conjunction with special surveys or routine monitoring.
8. Referrals from law enforcement agencies, i.e., the Attorney General's Office, Medicaid Fraud Control Unit, etc.

Ped-I-Care's Departmental supervisors are members of the Management Team which meets regularly. Supervisors educate staff at least quarterly regarding issues that need to be reported. This training includes examples specific to issues in which the department may become aware of through normal activities and functions. Employees in each area are required to report suspicions to the Compliance Department immediately.

The manner in which internal monitoring is conducted will be determined by the Compliance Department. Internal audits may occur without notice provided ahead of time. The Compliance Department may, but is not required to, request information from other departments. The Compliance Department does not require permission in order to conduct internal monitoring; this ensures there are no restrictions placed upon the process and guarantees access to all relevant information. The necessary information needed for monitoring is determined by the Compliance Department, not the internal area being monitored. In order to conduct thorough and accurate internal monitoring, the Compliance Department must have unrestricted access, at all times, to all of Ped-I-Care's internal departmental electronic and hardcopy folders, files, documents, etc.; this includes, but is not limited to, information maintained by all departments. Findings of internal and external audits are reported to the Compliance Officer and handled as appropriate.