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

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

Approved by:

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Officer</td>
<td>Mark Hudak, MD</td>
<td>Signature</td>
</tr>
</tbody>
</table>

Dates Revised

Ped-I-Care Approved

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

"
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:

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Ped-I-Care Compliance Officer
Professor and Chairman of Pediatrics
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Phone: 904-244-3508, Fax: 904-244-3777
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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
CMS CO – Children’s Medical Services Central Office
CCP – Community Care Plan
CEMC – Certified Evaluation and Management Coder
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

Objectives

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps Compliance Policies and/or Activities</th>
<th>Responsible Department or Person</th>
<th>Scheduled Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Policies</strong> (available at <a href="http://pedicare.pediatrics.med.ufl.edu/for-providers/compliance/">http://pedicare.pediatrics.med.ufl.edu/for-providers/compliance/</a>)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A. Maintain Compliance policies that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities</td>
<td>1. Create, review, and update Compliance policies</td>
<td>Compliance Officer &amp; Compliance Director</td>
<td>Annually &amp; as needed</td>
</tr>
<tr>
<td></td>
<td>2. Ensure policies, procedures, and standards of conduct clearly articulate Ped-I-Care’s commitment to comply with all applicable federal and state standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Review and adopt Ped-I-Care’s Compliance policies</td>
<td>Compliance Committee</td>
<td>Biennially</td>
</tr>
</tbody>
</table>

| II. Fraud, Waste, and Abuse Training and Education (See Attachment IV) | | | |
| A. Ped-I-Care Staff Training | 1. Train all Ped-I-Care staff | Compliance Department | Within 30 days of hire & annually As needed |
| | 2. Conduct necessary training as needs are identified | | Ongoing |
| | 3. Maintain record of all trainings | | |
### Objectives

<table>
<thead>
<tr>
<th>B. Ensure that details are provided to educate providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement an online fraud, waste, and abuse training module</td>
</tr>
<tr>
<td>2. Provide details regarding the availability of the training module on Ped-I-Care’s website and in the Provider Manuals</td>
</tr>
<tr>
<td>3. Review and update the information available on the Compliance page of Ped-I-Care’s website</td>
</tr>
<tr>
<td>4. Direct providers to training resources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Education of Delegated Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review delegated entity materials</td>
</tr>
<tr>
<td>2. Ensure education is provided</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Compliance Department Auditing Staff Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Auditors will receive CPMA or CEMC certification training</td>
</tr>
<tr>
<td>2. Auditors will obtain AAPC continuing education units related to medical chart auditing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Keep abreast of current fraud, waste, and abuse topics, issues, and activities throughout the state of Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attend AHCA’s Quarterly Meetings for Title XIX and CMS Meetings for Title XXI</td>
</tr>
<tr>
<td>2. Respond to AHCA’s and CMS’ requests for information</td>
</tr>
<tr>
<td>3. Provide suggestions and feedback on ways to improve communication and the detection of fraud and abuse</td>
</tr>
<tr>
<td>4. Review AHCA Final Order alert emails related to fraud and/or abuse</td>
</tr>
<tr>
<td>5. Send out educational email</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Steps Compliance Policies and/or Activities</th>
<th>Responsible Department or Person</th>
<th>Scheduled Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement an online fraud, waste, and abuse training module</td>
<td>Compliance Director</td>
<td>September 2011</td>
</tr>
<tr>
<td>2. Provide details regarding the availability of the training module on Ped-I-Care’s website and in the Provider Manuals</td>
<td>Compliance Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3. Review and update the information available on the Compliance page of Ped-I-Care’s website</td>
<td>Compliance Program Manager</td>
<td>Annually</td>
</tr>
<tr>
<td>4. Direct providers to training resources</td>
<td>Provider Liaisons</td>
<td>When added to the network and during ongoing training efforts</td>
</tr>
<tr>
<td>1. Review delegated entity materials</td>
<td>Each department responsible for daily activities oversight</td>
<td>Annually</td>
</tr>
<tr>
<td>2. Ensure education is provided</td>
<td>Annually and as needed</td>
<td></td>
</tr>
<tr>
<td>1. Auditors will receive CPMA or CEMC certification training</td>
<td>Compliance Auditors</td>
<td>Within 2 years of hire</td>
</tr>
<tr>
<td>2. Auditors will obtain AAPC continuing education units related to medical chart auditing</td>
<td>Compliance Auditors</td>
<td>Ongoing</td>
</tr>
<tr>
<td>1. Attend AHCA’s Quarterly Meetings for Title XIX and CMS Meetings for Title XXI</td>
<td>Compliance Director and/or Audit Manager</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2. Respond to AHCA’s and CMS’ requests for information</td>
<td>Compliance Department if request is specific to fraud and abuse auditing; Applicable Department otherwise</td>
<td>As needed</td>
</tr>
<tr>
<td>3. Provide suggestions and feedback on ways to improve communication and the detection of fraud and abuse</td>
<td>Compliance Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4. Review AHCA Final Order alert emails related to fraud and/or abuse</td>
<td>Compliance Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5. Send out educational email</td>
<td>Compliance</td>
<td>Periodically</td>
</tr>
<tr>
<td>Objectives</td>
<td>Action Steps Compliance Policies and/or Activities</td>
<td>Responsible Department or Person</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>alerts to staff of fraud and abuse cases throughout the country</td>
<td></td>
<td>Auditors</td>
</tr>
</tbody>
</table>

### III. Auditing and Monitoring

**A. Ensure that Ped-I-Care staff have received Fraud, Waste, 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 Data Manager**
   - **Compliance Program Manager**
   - **Quarterly**

**B. Maintain a Fraud, Waste, and Abuse Hotline**

1. Monitor the dedicated, confidential hotline for reporting suspected fraud, waste, or abuse
2. Investigate allegations in a timely manner
   - **Compliance Department**
   - **Ongoing**

**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**
   - **Executive Director**
   - **Executive Director**
   - **Department Manager(s)**
   - **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 education
7. Create Corrective Action Plans (CAP) when appropriate
8. Evaluate adherence to and effectiveness of CAP
9. Document findings and
   - **CMS, All Departments, and MED3000 Compliance Department**
   - **Ongoing**
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps Compliance Policies and/or Activities</th>
<th>Responsible Department or Person</th>
<th>Scheduled Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Ensure compliance of each Ped-I-Care department/staff with policies, procedures, and all contractual obligations</td>
<td>1. Review all policies, procedures, contracts, contract amendments, and applicable statues and regulations</td>
<td>All Departments</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>2. Each department is monitored by the department supervisor for compliance</td>
<td>Department Supervisor</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>3. Conduct internal audits to ensure compliance with contract requirements, policies, and procedures</td>
<td>Department Supervisor</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>4. Document audit results</td>
<td>Department Supervisor</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>5. Analyze areas needing improvement</td>
<td>Department Supervisor</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>6. Review adverse findings with the Executive Director and the Compliance Director</td>
<td>Department Supervisor</td>
<td>When identified</td>
</tr>
<tr>
<td></td>
<td>7. Create CAP to address deficiencies within 14 days of detection</td>
<td>Department Supervisor</td>
<td>When deficiencies are identified</td>
</tr>
<tr>
<td></td>
<td>8. Send CAP to the Executive Director and Compliance Director for review and comment</td>
<td>Department Supervisor</td>
<td>Within 14 days of detecting the need for a CAP</td>
</tr>
<tr>
<td></td>
<td>9. Implement the CAP after approval</td>
<td>Department Supervisor</td>
<td>Within 1 week of approval</td>
</tr>
<tr>
<td></td>
<td>10. Evaluate adherence to and effectiveness of CAP</td>
<td>Department Supervisor</td>
<td>At least monthly</td>
</tr>
<tr>
<td></td>
<td>11. Report completion of CAP items to the Compliance Department</td>
<td>Department Supervisor</td>
<td>Upon completion</td>
</tr>
<tr>
<td></td>
<td>12. Develop and perform education needs assessment for staff</td>
<td>Department Supervisor</td>
<td>When issues are identified &amp; Annually</td>
</tr>
<tr>
<td></td>
<td>13. Perform any necessary staff education</td>
<td>Department Supervisor</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>14. Document details of education efforts</td>
<td>Department Supervisor</td>
<td>When performed</td>
</tr>
<tr>
<td></td>
<td>15. Report education efforts to the Compliance Department</td>
<td>Department Supervisor</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>16. Document findings and outcomes in Compliance records</td>
<td>Compliance Department</td>
<td>Ongoing</td>
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F. Investigate potential

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Research issue</td>
<td>Compliance</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Objectives</td>
<td>Action Steps Compliance Policies and/or Activities</td>
<td>Responsible Department or Person</td>
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<tr>
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</table>
| compliance issues reported by email, regular mail, fax, phone, in person, or through any other means | 2. Perform audit if needed and/or refer issue to appropriate department/area/organization to address  
3. If not referred out, analyze areas needing improvement  
4. Perform any necessary education  
5. Create CAP to address deficiencies  
6. Evaluate adherence to and effectiveness of CAP  
7. Document findings and outcomes in Compliance tracking database | Department |                                                                                          |
| G. Ensure no Ped-I-Care staff or providers are on the List of Excluded Individuals and Entities (LEIE) or System for Award Management (SAM) (which includes the former Excluded Parties List System [EPLS]) | 1. Compare newly recruited providers and entities to the LEIE and SAM  
2. Compare new Ped-I-Care staff to the LEIE and SAM  
3. Compare existing providers and entities to the LEIE and SAM  
4. Investigate possible matches  
5. Notify the Contracting and Compliance Departments of any matches  
6. If matches are identified, contact the Legal Department  
7. Remove the identified individual/entity from any work or service that is federally funded  
8. Notify the Compliance Department of any actions and outcomes  
9. Maintain information for reporting purposes  
10. Report information to the Compliance Committee  
11. Submit fiscal year data to Compliance Data Manager for inclusion in the Annual Fraud and Abuse Activity Report | Contracting Department  
UF Human Resources Department  
Compliance Support Assistant  
Compliance Program Manager  
Department that identifies match  
Contracting Department  
Contracting Department  
Contracting Department  
Contracting Department  
Contracting Department | Prior to contracting  
Prior to hire  
Monthly  
When identified  
When identified  
Immediately  
Immediately when instructed by legal  
Immediately  
Ongoing  
Every 6 months during meetings  
Annually by July 15 | |
| H. Review AHCA Final                                                                                         | 1. Compare the providers listed as | Compliance | Monthly |

Ped-I-Care Compliance Program  
CD-0002: Compliance and Anti-Fraud Plan  
Last Approved on 9/25/2017  
Last Revised on 8/1/2017
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</thead>
<tbody>
<tr>
<td>Orders</td>
<td>suspensions or terminations in the AHCA Final Orders on AHCA’s website to the provider network 1. Notify the Contracting and Compliance Departments of any provider matches 2. If appropriate, take action to exclude provider, facility, and group matches from participation in the network and follow steps as outlined in G. above</td>
<td>Support Assistant Compliance Support Assistant Contracting Department</td>
<td>As identified Within 5 calendar days of detection</td>
</tr>
<tr>
<td>I. Review Termination Notices from AHCA</td>
<td>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 2. Notify the Contracting and Compliance Departments of any provider matches 3. Take appropriate action to exclude provider and entity matches from participation in the network as outlined in G. above</td>
<td>Contracting Department prior to contracting and CMS as notices are sent Contracting Department and CMS Contracting Department and CMS</td>
<td>Prior to contracting with a provider and within 3 business days of receiving the notice When identified Within 5 calendar days</td>
</tr>
<tr>
<td>J. Develop Compliance Database</td>
<td>1. Create database for reporting and tracking of Compliance activities 2. Test database 3. Make adjustments as needed 4. Document all Compliance findings and outcomes in tracking database</td>
<td>Compliance Data Manager Compliance Department Compliance Data Manager Compliance Department</td>
<td>February 2012 March 2012 Within 1 week of identification (sooner if critical) Ongoing</td>
</tr>
<tr>
<td>K. Verify with members that services billed by providers were received</td>
<td>1. Determine method to verify provided services with members 2. Discuss billed services with members during regular contact and eligibility redetermination</td>
<td>CMS CMS Nurse Care Coordinators</td>
<td>December 2013 Ongoing</td>
</tr>
<tr>
<td>Objectives</td>
<td>Action Steps Compliance Policies and/or Activities</td>
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</tr>
<tr>
<td>3. Using random sampling of claims payments, attempt to reach the member/family by phone or mail in order to verify service delivery</td>
<td>Member Services</td>
<td>Quarterly, starting Q4 2017</td>
<td></td>
</tr>
<tr>
<td>4. Investigate allegations of services not provided or billed incorrectly</td>
<td>Compliance Department</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>

**IV. Reporting**

A. For Title XIX notify AHCA’s MPI and for Title XXI notify CMS Contract Manager of suspected or confirmed cases of fraud, waste, and/or abuse

1. Submit notice of concern
   - Compliance Department
   - Within 15 calendar days of detection
   - Quarterly

2. Submit investigation information on the quarterly report

B. 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, maintain records of, and report the following to 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:
   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 entry into the network for program integrity-related reasons
   d. The identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, individuals with ownership

   - CMS Central Office, CCP, and Contracting Department
   - Ongoing
<table>
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<tr>
<td></td>
<td>or control interest in a network provider, or subcontractor, or is an agent or managing employee of a network provider or subcontractor affected by or applicable to 1. a., b., or c. above 2. Send notification and supporting information to the DHHS OIG (as instructed by AHCA)</td>
<td>CMS Central Office</td>
<td>Within 10 business days of discovery</td>
</tr>
<tr>
<td>C. Notify the CMS Contract Manager and Ped-I-Care’s Compliance Department of executed corporate integrity or corporate compliance agreements imposed for Ped-I-Care</td>
<td>1. Send notification and a copy of the agreement(s) to the CMS Contract Manager and Ped-I-Care’s Compliance Department 2. For Title XIX, CMS will notify AHCA’s MPI</td>
<td>Ped-I-Care Executive Director</td>
<td>Within 30 days of execution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS Central Office</td>
<td>Immediately</td>
</tr>
<tr>
<td>D. Notify the CMS Contract Manager and Ped-I-Care’s Compliance Department of any corrective action plans required by the Department of Financial Services (DFS) and/or federal governmental entities, excluding AHCA, imposed for Ped-I-Care</td>
<td>1. Send notification a copy of the corrective action plans to the CMS Contract Manager and Ped-I-Care’s Compliance Department 2. For Title XIX, CMS will notify AHCA’s MPI</td>
<td>Ped-I-Care Executive Director</td>
<td>Within 30 days of execution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS Central Office</td>
<td>Immediately</td>
</tr>
<tr>
<td>E. Notify the Compliance Committee</td>
<td>1. Provide a summary of providers excluded from participation in the network to the Compliance Officer and Compliance Director 2. Provide a summary of investigations and Compliance Department activities to the Compliance Officer 3. Present a summary of investigations, activities, providers excluded from</td>
<td>Provider Network and Contracting Manager  Compliance Director  Compliance Officer</td>
<td>No less than 3 weeks prior to Compliance Committee Meetings Prior to Compliance Committee Meetings Biannually during meetings</td>
</tr>
<tr>
<td>Objectives</td>
<td>Action Steps Compliance Policies and/or Activities</td>
<td>Responsible Department or Person</td>
<td>Scheduled Completion Date</td>
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</tr>
<tr>
<td>F. Review the results of investigations of fraud, waste, abuse, or overpayment conducted during the previous fiscal year (See Attachment II)</td>
<td>1. Create a report, verify/research the accuracy the data, and submit it to the Compliance Director and Program Manager for review</td>
<td>Compliance Data Manager</td>
<td>Annually by July 15&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2. Revise and submit the final report to the Compliance Director</td>
<td>Compliance Data Manager</td>
<td>Annually by July 29&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3. Review the results and send to the Compliance Officer</td>
<td>Compliance Director</td>
<td>Annually by August 15&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>4. Review the results and provide feedback to the Compliance Director</td>
<td>Compliance Officer</td>
<td>Annually by August 20&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>5. Submit the Title XIX and Title XXI reports to the CMS Contract Manager for review</td>
<td>Compliance Director</td>
<td>Annually by September 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>6. For Title XIX, submit the report and attestation to the AHCA MPI SFTP site</td>
<td>CMS Contract Manager</td>
<td>Annually by September 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>G. Review Compliance &amp; Anti-Fraud Plan</td>
<td>1. Update the plan after meeting with the Compliance Director</td>
<td>Compliance Program Manager</td>
<td>Annually in January</td>
</tr>
<tr>
<td></td>
<td>2. Submit it to the Compliance Auditors for review</td>
<td>Compliance Program Manager</td>
<td>Annually in February</td>
</tr>
<tr>
<td></td>
<td>3. Review, revise, and submit the final plan to the Compliance Director</td>
<td>Compliance Program Manager</td>
<td>Annually by March 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>4. Review, revise, and submit the final plan to the Compliance Officer</td>
<td>Compliance Director</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>5. Review the plan and provide feedback to the Compliance Director</td>
<td>Compliance Officer</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>6. Present the plan to the Compliance Committee for approval</td>
<td>Compliance Officer</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>7. Submit the plan to the CMS Contract Manager for review</td>
<td>Compliance Director</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>8. Submit the plan for Title XIX to the AHCA MPI SFTP site</td>
<td>CMS Contract Manager</td>
<td>Annually by September 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**V. Staffing**

<table>
<thead>
<tr>
<th>A. Maintain an organizational chart outlining the</th>
<th>1. Create organizational chart</th>
<th>Compliance Program Manager</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Review and update the organizational chart</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ped-I-Care Compliance Program
CD-0002: Compliance and Anti-Fraud Plan
Last Approved on 9/25/2017
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Action Steps Compliance Policies and/or Activities</th>
<th>Responsible Department or Person</th>
<th>Scheduled Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>arrangement of the personnel responsible for the investigation and reporting of possible waste, overpayment, billing abuse, or fraud</td>
<td>(See Attachment I)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| B. Evaluate staffing needs | 1. Review workload and determine the type and amount of staff needed to effectively operate the Compliance Department  
2. Discuss findings with Compliance Officer | Compliance Department  
Compliance Director | Annually  
Annually |
| C. 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  
Compliance Director and Compliance Program Manager | As needed  
Upon hire |
Annual Fraud and Abuse Activity Report Summary

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

July 1, 2016 – June 30, 2017

(Reported September 1, 2017)

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Referrals</th>
<th>Investigated</th>
<th>Closed</th>
<th>Identified</th>
<th>Recovered</th>
<th>Pending Recovery</th>
<th>Uncollectible</th>
<th>Identified</th>
<th>Recovered</th>
<th>Dollars Lost to Fraud &amp; Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX 65 to MPI</td>
<td>69</td>
<td>263</td>
<td>109</td>
<td>$60,643.21</td>
<td>$9,906.39</td>
<td>$636.78</td>
<td>$50,100.04</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$16,307.87</td>
</tr>
<tr>
<td>Title XXI 4 to CMS</td>
<td>69</td>
<td>179</td>
<td>98</td>
<td>$40,955.84</td>
<td>$6,401.48</td>
<td>$153.13</td>
<td>$34,401.23</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>442</td>
<td>207</td>
<td>$101,599.05</td>
<td>$16,307.87</td>
<td>$789.91</td>
<td>$84,501.27</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$16,307.87</td>
</tr>
</tbody>
</table>

A recoupment process was initiated by CMS in February 2017. For claims that Florida's statutory time limit (Section 641.3155 F.S.) applies, recoupment is not pursued.

Providers Terminated From Network Participation

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 - Physician (M.D.)</td>
<td>3</td>
</tr>
<tr>
<td>26 - Physician (D.O.)</td>
<td>1</td>
</tr>
<tr>
<td>35 - Dentist</td>
<td>1</td>
</tr>
<tr>
<td>83 - Therapist (PT, OT, ST, RT)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
</tr>
</tbody>
</table>
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, waste, and abuse through a collaborative effort. Appropriate enforcement measures based on compliance findings will be undertaken after consultation with or notification of AHCA and CMS. Fraud can manifest in multiple ways and we solicit and anticipate the cooperation of diligent staff, subcontractors, 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, waste, and billing abuse. All activities seen as fraud, waste, and/or billing abuse will be reported to the Ped-I-Care Compliance Department for investigation and follow-up. Employees, providers, and subcontractors must comply with all aspects of Ped-I-Care’s Compliance Program and its fraud, waste, and abuse plan/requirements.

Compliance Activities and Investigations

Ped-I-Care proactively conducts both prospective and retrospective searches and analyses to seek potential fraud, waste, 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, waste, and/or abuse, chart audits may be conducted without prior notice. Findings suggestive of fraud, waste, and/or abuse will be reported as appropriate and needed to the Office of Medicaid Program Integrity (MPI) for Title XIX and CMS for Title XXI. 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 Education

Ped-I-Care’s Compliance Program educates providers and their staff members and investigates fraud, waste, and abuse. Providers and practices are responsible for ensuring they and their staff are adequately educated regarding fraud, waste, and abuse. Ped-I-Care’s online training tutorial is available at [http://pedicare.peds.ufl.edu/compliance/index.html](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 educate providers and staff. Additionally, educational information is available on the Compliance page ([http://pedicare.pediatrics.med.ufl.edu/for-providers/compliance/](http://pedicare.pediatrics.med.ufl.edu/for-providers/compliance/)) and Fraud, Waste, & Abuse Prevention page ([http://pedicare.pediatrics.med.ufl.edu/for-providers/fraud-and-abuse-prevention/](http://pedicare.pediatrics.med.ufl.edu/for-providers/fraud-and-abuse-prevention/)) of Ped-I-Care’s website.

Compliance Requirements

Ped-I-Care providers are expected to adhere to the following guidelines for medical records and claims. Note that it is not an all-inclusive list; it is a list of findings commonly identified during medical record and claims audits.

Providers/practices must:
1. Ensure documentation is legible;
2. Ensure documentation supports what is billed on the claim;
3. Ensure documentation supports billed modifiers;
4. Ensure the site/practice location of where services were rendered is documented in the note (if a practice has multiple locations, the location for each encounter must be clear in each note);
5. Ensure the Chief Complaint is documented (the medical reason for a “follow-up” visit must be documented);
6. Ensure each note’s documentation is unique and specific to the presenting problem(s)/reason for the encounter (be careful of copy/paste, cloning, and bringing forward information from other encounters);
7. Ensure notes do not contain conflicting information (i.e. an assessment of Acute Respiratory Infection with no complaint of cough, runny nose, or difficulty breathing and normal respiration, lungs, ears, nose, and throat documented on the exam);
8. Ensure the exam and service(s) rendered support the medical necessity of the reason for the encounter/presenting problem(s);
9. Ensure all procedures are documented in medical record;
10. Ensure subsequent pages of each note contain patient identifying information;
11. Ensure if billing based on time, that the medical record documentation includes a statement regarding the total time spent with the patient AND a concise description of the content of the counseling that was provided;
12. Ensure notes are signed in a timely manner (providers are expected to sign all records within a reasonable time frame, usually 48-72 hours of an encounter);
13. Ensure electronic signatures are dated;
14. Ensure the claim is NOT billed before the note is signed by the attending provider;
15. Ensure each claim is submitted in the name of the provider that actually rendered services and signed (or co-signed in accordance with incident-to requirements) the note; and
16. Ensure errors in the chart are corrected appropriately.

From the Medicare Handbook:

<table>
<thead>
<tr>
<th>Signature Requirement</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Legible full signature</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2 Legible first initial and last name</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3 Illegible signature over a typed or printed name</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4 Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the signatory. &lt;br&gt;&lt;br&gt;Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians’ names. One of the names is circled.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5 Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a signature log, or an attestation</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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 CMS and Ped-I-Care. Providers, facilities, groups, and subcontractors must notify Ped-I-Care immediately if they or any of their staff are or become ineligible to participate in federally funded programs or receive federal money.

Reporting Fraud, Waste, and Abuse

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

You may report suspected cases of fraud, waste, 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, Waste, & 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, 3rd Floor
  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.
As stated in the CD-0005 Compliance, Fraud, Waste, and Abuse Training Policy:


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

3. The 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, waste, and abuse
   b. Fraud, Waste, 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, Waste, 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 maintains documentation of any employee training not conducted online.

4. Members are educated about fraud, waste, 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.
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/manager-resources/employee-relations/disciplinary-processes/](http://hr.ufl.edu/manager-resources/employee-relations/disciplinary-processes/). 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, has been charged or convicted of Medicare or Medicaid fraud, other professional misconduct or criminal conduct, or if the provider is in violation of any provision of the contract.

Ped-I-Care’s Fraud, Waste, 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 CMS credentialing/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)
Ped-I-Care Compliance Officer
Ped-I-Care Associate Medical Director
Chair, Department of Pediatrics, UF Jacksonville
Professor and Chief, Division of Neonatology, UF
College of Medicine, Jacksonville
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mark_hudak@jax.ufl.edu; 904-244-3508; Fax: 904-244-3777
Christina Bennett, Executive Assistant
Phone: 904-244-3056; Fax: 904-244-3028
Christina.Bennett@jax.ufl.edu

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Ped-I-Care Medical Director
UF Department of Pediatrics, Clinical Associate Professor
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fillidj@peds.ufl.edu
352-627-9309; Fax: 352-294-8096

Donna Burch, Administrative Support Assistant III
Phone: 352-627-9195; Fax: 352-294-8078
dkburch@peds.ufl.edu

Sherry Buchman, RN
Regional Executive Nursing Director, North Central Region
Florida Department of Health, Children’s Medical Services
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Jacksonville, FL 32209
Sherry.Buchman@flhealth.gov
904-798-4118; Fax: 904-798-4568

Sara Miller
Interim CMS Compliance Officer
CMS Managed Care Plan Administration
Florida Department of Health
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Tallahassee, FL 32399-1707
Sara.Miller@flhealth.gov
850-901-6329; Fax: 850-413-8782

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Ped-I-Care Executive Director
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Gainesville, FL 32608
lherndon@peds.ufl.edu; 352-627-9125
Donna Burch, Administrative Support Assistant III
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dkburch@peds.ufl.edu

Karen Graham Tillman, JD, LHRM, CHC
Assistant University Counsel for Contracts - Ped-I-Care
1699 SW 16th Avenue, Room 3212
Gainesville, FL 32608
ktillman@ufl.edu
Direct line: 352-273-7222 (OGC-CU)
or
352-627-9211 (Ped-I-Care); Fax: 352-294-8078

Jennifer Barry, MHA, BSN, RN, CPC, CPMA, CPCO, CPC-I
Ped-I-Care Assistant Director for Compliance and Quality Improvement
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Gainesville, FL 32608
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Karen Billings, MPA
Ped-I-Care Assistant Director for Finance, Human Resources, & Claims
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Kati Breton, BS
Ped-I-Care Assistant Director for Network and Contracting
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Marc Grasley, MS, MSN, ICGB
Ped-I-Care Assistant Director for Member Services
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Holly Estep, BSN, RN, CCM
Ped-I-Care Assistant Director for Utilization Management
1699 SW 16th Avenue, Room 3156
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hestep@peds.ufl.edu; 352-627-9128
Compliance Officer

This position is responsible for the Compliance Program that will identify, report, and prevent fraud, waste, and billing abuse among Ped-I-Care providers and members. Ped-I-Care is a University of Florida Department of Pediatrics health care program 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, fraud, waste, and billing abuse without fear of retaliation. This position ensures the plan’s management, employees, contracted physicians, and subcontractors are in compliance with the fraud, waste, and abuse rules and regulations of regulatory agencies, that policies and procedures are followed, and that behavior in the organization is consistent with Ped-I-Care’s Code 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, waste, and billing abuse among Ped-I-Care employees, providers, and members. 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, waste, and billing abuse. Once there is evidence that there may be fraud, waste, and/or billing abuse, Title XIX cases are reported to the Medicaid Office of Program Integrity and Title XXI 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, fraud, waste, and billing abuse without fear of retaliation. This position must implement and maintain effective auditing and monitoring systems and protocols to evaluate provider and member 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 Ped-I-Care’s Executive Director. This position keeps the Compliance Officer abreast of concerns.

Compliance Program Manager

This position functions as manager of administrative functions for the Compliance Program and is responsible for supervising staff that schedule chart audits and reviews; preparing all investigation and training materials for the Compliance Department; entering and maintaining
accurate data regarding investigations 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 Compliance 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 fraud, waste, and billing abuse. Chart audits and education are conducted based on the results of these reviews. Random chart audits are also conducted to identify potential fraud, waste, and billing abuse. This position is responsible for monitoring the Ped-I-Care Fraud, Waste, 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 database, and provides data for reporting when needed. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Data Manager

This position is responsible for analyzing, entering, and maintaining accurate data in Compliance databases; creating forms; creating and reviewing reports; ensuring the fraud, waste, and abuse training module is updated and data is accurate; maintaining training logs; coordinating technical needs and updates; and other reporting and administrative duties. This position is under the direct supervision of and reports to the Compliance Director.

Compliance Application Programmer II

This position serves as technical support for the Compliance Program and is responsible for developing and maintaining systems, databases, interfaces, auditing forms, data mining, reporting, the web portal, and the training website. This position ensures that new and existing employees and providers have access to the online Ped-I-Care Fraud, Waste, and Abuse Training module and maintain the training logs. The position is under the direct supervision of and report 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, waste, 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, waste, 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 addressing Ped-I-Care fraud, waste, and abuse hotline complaints and any concerns that may be obtained through other reporting channels. 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, waste, 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 special investigation unit staff. Chart audits are conducted based on the results of claims data review and/or complaints received regarding potential fraud, waste, and/or billing abuse. Random chart audits are also conducted to identify potential fraud, waste, and billing 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, correct health care coding and billing procedures and practices, Centers for Medicare and Medicaid Services guidelines for addressing fraud, waste, 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 Specialist I and II)**

This position is responsible for working with the Ped-I-Care Compliance Department, Compliance Officer, Compliance Director, Compliance Audit Specialists 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, Ped-I-Care Medical Directors, CMS Nurse Care Coordinators (NCCs), the Third Party Administrator (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 or Compliance Training Manager.

**Compliance Audit Assistants**

This position functions as program support to the Compliance Program and is responsible for scheduling and obtaining documentation for audits reviews. This position prepares and organizes needed information for the Compliance Director, Officer, and Auditors. This position is responsible for preparing all visit and education materials for the Compliance Department; entering and maintaining accurate data regarding chart reviews and education; 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 fraud and billing abuse. Chart audits and education are conducted based on the results of these reviews. This position gives support to the Compliance Department, maintains the Compliance database, and provides data for investigations and reporting when needed. This position is under the direct supervision of and reports to the Compliance Program Manager.
Abuse (program integrity related): Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care, or member practices that result in unnecessary costs.

Examples of Provider Abuse:
- Provider billing irregularities
- Over-utilization of health care services
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Unintentional improper billing practices
- Unintentional inaccurate coding

Examples of Member Abuse:
- Residing out-of-state
- Tampering with prescriptions
- Drug-seeking behaviors
- Failure to report third-party liability
Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person 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.
- 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 Medicaid or CMS, as a result of referring a patient to the other provider
- Duplicate billing such as billing Medicaid or CMS and another payer and/or the member for the same service
- Misrepresentation of professional credentials/licensing/status of licensure
- 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 performed 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 under-reporting income, assets, resources, etc.
- Loaning a Medicaid or CMS identification card to another person
- Using multiple ID cards and/or Medicaid/member numbers
- Forging or altering a prescription or fiscal order
- Intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies
- Re-selling items paid for by the health plan
- Misrepresentation of a medical condition

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

Examples of Overpayment:
Attachment VIII – Definitions and Examples

- Payment for provider, supplier, or physician services after benefits have been exhausted, or where the member was not entitled to benefits
- Payment for non-covered 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

**Waste:** It is not defined in the rules, but “is generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.” Examples of waste by a beneficiary could include making excessive office visits or accumulating more prescription medications than necessary for the treatment of specific conditions. Waste by a provider could include ordering excessive laboratory tests such as a comprehensive metabolic panel; ordering a group of blood tests, when only one or less tests are needed; ordering magnetic resonance imaging (MRI) instead of a mammogram for preventive care; or delays in treatment that leads to unnecessary costs.

**Additional Examples of Waste:**
- **Failures of care delivery** – Poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or patient safety best practices, which can result in patient injuries, worse clinical outcomes, and higher costs
- **Failures of care coordination** – Fragmented and disjointed care can lead to unnecessary hospital readmissions, avoidable complications, and declines in functional status, especially for the chronically ill
- **Overtreatment**
  - Prescribing drugs in a manner that is inconsistent with best practices, such as excessive use of antibiotics
  - Care that is rooted in outmoded habits
  - Ordering clinical procedures, tests, medications, and other services that may not benefit patients
  - Providers' preferences for treatment that is beyond/outside of that considered necessary and appropriate by industry standards
  - Scheduling more visits than is medically necessary
  - Ordering unnecessary tests or diagnostic procedures to guard against liability in malpractice lawsuits
  - Over-diagnosis stemming from efforts to identify and treat disease in its earliest stages when the disease might never actually progress and when a strategy such as watchful waiting may have been preferred. For example, in July 2012 the US Preventive Services Task Force recommended against prostate-specific antigen-based screening for prostate cancer because of "substantial over-diagnosis" of tumors, many of which are benign. Excessive treatment of these tumors, including surgery, leads to unnecessary harms, the task force said.
All personnel and departments are responsible for notifying the Compliance Department of potential and suspected fraud, waste, and/or billing 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, subcontractors, 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 or other subcontractors.
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 education 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 and all levels of the organization. Findings of internal and external audits are reported to the Compliance Officer and handled as appropriate.