BBHC

BROWARD BEHAVIORAL HEALTH COALITION

Fraud, Waste, and Abuse Prevention Plan FY 2020 - 2021

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FRAUD, WASTE, AND ABUSE PLAN
BROWARD BEHAVIORAL HEALTH COALITION

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PURPOSE

The purpose of the Fraud, Waste and Abuse Prevention Plan is to describe Broward Behavioral Health Coalition Inc.'s (BBHC's) organizational commitment to conducting business ethically, with integrity, and in compliance with applicable laws, regulations and requirements. BBHC requires its subcontractors and network service providers, vendors, and related entities a similar commitment to ethical conduct and assurance that they and their employees, representatives, and subcontractors comply with the guiding principles outlined within this plan.

BBHC's Fraud, Waste and Abuse Plan details the prevention, detection, investigation, recovery, and reporting of all suspected cases of fraud, waste and/or abuse, both internally and externally. BBHC and all of its vendors, subcontractors and its service providers have a fiduciary responsibility to resist criminal behavior, instances of false claims, improper billing or coding practices, and other patterns that adversely impact consumer safety, quality of care, and impose a financial burden on the behavioral health care system.

BBHC takes fraud, waste and abuse seriously. BBHC shall notify the Department of Children and Families (DCF), Substance Abuse Mental Health (SAMH) Program Office of all fraud, waste and abuse cases and will also notify law enforcement and the Office of Inspector General, as appropriate. BBHC will work with DCF SAMH Program Office, law enforcement, and the Office of Inspector General for appropriate remedies/sanctions. In addition, as BBHC has subcontracted Contract Management, Data Collection and Billing to Carisk Partners (Carisk), BBHC will coordinate all applicable activities with Carisk.

BBHC promotes practices that are compliant with federal and state laws on fraud, waste, and abuse. BBHC's expectation is that its subcontracted providers will submit accurate invoices for actual services rendered, not abuse processes or allowable benefits, and exercise their best independent judgment when deciding how to best serve consumers in need of service.

BBHC does not tolerate fraud, waste, or abuse, either by subcontracted service providers or staff. Accordingly, BBHC has instituted fraud, waste, and abuse strategies to combat any issues that may arise. BBHC's strategies are wide-ranging and multi-faceted, focusing on prevention, detection, and investigation of all types of fraud, waste, and/or abuse.

Both BBHC and subcontracted service providers are subject to federal and state laws designed to prevent fraud, waste and abuse in government programs and federally funded contracts. BBHC complies with all applicable laws, including the Federal False Claims Act, state false claims laws, applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded health care programs (e.g., Medicare and Medicaid) and other payers.

DEFINING FRAUD, WASTE, AND ABUSE

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste: Over-utilization of services or other practices that result in unnecessary costs.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded health care programs and other payers.

Some examples of fraud, waste, and abuse include:

1. Billing for services or procedures that have not been performed or have been performed by others
2. Submitting false or misleading information about services performed
3. Delivery of services by unqualified staff
4. Misrepresenting the services performed (e.g., up-coding to increase reimbursement);
5. Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
6. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute which now constitutes a false or fraudulent claim under the False Claims Act
7. Routinely waiving consumer co-payments
8. Providing or ordering medically unnecessary services and tests based on financial gain
9. An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient);
10. An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., therapist billing two individual psychotherapy sessions on the same day for the same patient);
11. Providing services over the telephone or Internet and billing using face-to-face codes
12. Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of consumers allowed per group session)
13. Treating all consumers weekly regardless of necessity
14. Routinely maxing out of consumers benefits or authorizations regardless of whether or not the services are necessary
15. Inserting a diagnosis code not obtained from a physician or other authorized individual
16. Violating another law (e.g., billing is submitted appropriately but the service was the result of an illegal relationship such as a physician receiving kickbacks for referrals)
17. Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs
18. Lying about credentials, such as degree and licensure information
19. Misuse of consumer funds through network service providers

20. Charging consumer co-payments not consistent with sliding fee scales
21. Network service providers not billing Medicaid for Medicaid eligible consumers
22. Theft - taking the property of another without right or permission
23. Failure to report known or suspected neglect or abuse of client.

ANTI-FRAUD GOALS AND ACTIVITIES

BBHC's goals and priorities are vital to its anti-fraud program success. Significant benefits include:

1. Quality - Improving the quality of consumer care is a priority.
2. Customer Relations – BBHC's effective anti-fraud program demonstrates its strong commitment to honest and responsible provider and corporate conduct.
3. Assessment of Risk – BBHC facilitates a more accurate view of risk and exposure relating to fraud, waste and abuse.
4. Public, Legislative and Contract Compliance - BBHC facilitates compliance with state/federal laws and effective contracts, and demonstrates a strategic approach to fighting fraud, waste and abuse.
5. Civic Responsibility – BBHC believes that identifying and preventing fraud, waste and abuse through criminal and unethical conduct is considered a public duty.
6. Financial Savings – BBHC's prioritizes prevention, early detection, and recovery, minimizing false claims and loss to the State of Florida and its taxpayers.
7. Deterrence - Future deterrence of fraud, waste and abuse is a priority.
8. Objective Invoice Review - Standard, unbiased invoice review is required by law and is smart business.

BBHC implements and regularly conducts fraud waste, and abuse prevention activities that include:

1. Monitoring and auditing provider utilization and billing to detect fraud, waste and abuse
2. Actively investigating and pursuing allegations of fraud, waste and abuse and other alleged illegal, unethical or unprofessional conduct
3. Reporting suspected fraud, waste and abuse and related data to state and federal agencies, in compliance with applicable federal and state regulations and contractual obligations
4. Cooperating with law enforcement authorities in the prosecution of health care fraud cases
5. Verifying payment source eligibility for consumers
6. Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned
7. Making the BBHC Utilization Management policies and protocols available to network service providers
8. Ensuring that the contract between BBHC and Carisk is submitted and up to date with the Department of Children and Families Substance Abuse Mental Health Contract

FRAUD, WASTE, AND ABUSE PLAN

The components of the BBHC Plan are as follows:

I. External and Internal Prevention, Detection, and Investigation
II. Recovery
III. Reporting
IV. Education and Training
V. Primary Contact Person

I. PREVENTION, DETECTION, INVESTIGATION OF FRAUD, WASTE AND ABUSE

A. External Fraud, Waste and Abuse

1. Prevention and Detection

BBHC strives to detect and prevent health care fraud, waste and abuse through several avenues to include, but not limited to; complaints/grievances, incident reports or incident trends, data reports, monitoring and through the use of sophisticated fraud detection-based methodologies. BBHC will coordinate prevention and detection activities through quality assurance and monitoring.

2. Fraud Detection Technology

Data will be routinely and randomly analyzed by the IT and Fiscal Departments, based upon tips from all sources, to include external subcontractors and vendors specific to providers, facilities, and consumers, as well as independent research. This data analysis will be critical in the identification of repetitive fraud, waste, and abuse patterns. Output reports will be used for existing cases as well as the basis for new ones.

BBHC will utilize data mining capabilities and other technological tools in preventing and detecting fraud, waste, and abuse as well as explore the feasibility of employing the advanced technological tools of external vendors.

Data mining refers to the practice of electronically sorting Management Information Systems data to uncover patterns and relationships contained within the data activity and history. These patterns can then be seen as a kind of summary of the input data, and may be used in further analysis to identify abnormal utilization and billing practices that are potentially fraudulent. The overall goal of the data mining process is to extract information from a data set and transform it into an understandable structure.

Data mining is used to determine possible overutilization and other deviations from expected values and norms associated with reimbursement for substance abuse and mental health services. Based on the analysis, subcontracted providers that standout may be selected for auditing. Ongoing computer-based analysis of provider, facility, consumer, and service data is important. Patterns of over-utilization, false claims, or other unusual billing practices are addressed.

B. Provider Fraud, Waste, and Abuse

1. Detection

BBHC uses the following mechanisms to detect potential fraud, waste and abuse:

a) Trending of provider complaints, billing and utilization patterns

b) BBHC's data system automatically flags common service data errors for validation such as: Funding Source, Overlapping Services, Residential Levels 1 and 2 service + Other Service, Missing or Invalid Service Start time, Start time before 7 am, Units of Service (Procedure vs. Covered Services), Unknown procedure code, Site code, Invalid combination of covered services, program or funding combination, Invalid Contract number, Last Residential Day, Procedure vs. program, consumer ineligible to receive service and provider not eligible to provide service. During the processing and review of invoices, BBHC reviews dates of service to determine if any billing has been submitted for services that did not get automatically flagged for validation.

c) Review of HHS Office of Inspector General (OIG) exclusions and state license actions and updates for identified, excluded/unlicensed providers. BBHC terminates provider contracts for excluded providers

d) Consumers, providers and stakeholders may report fraud, waste and abuse by calling the BBHC toll-free number (877) 698-7794

e) Payment review methodologies will be utilized to detect suspicious cases to include: up- coding, bundling/unbundling, and utilization patterns

f) Invoice validation to compare YTD invoiced services to YTD data

g) Reporting of any information to BBHC and Carisk from staff, consumers, or providers and State and Federal agencies.

2. Fraud /Suspicious Billing Notification Sources

The identification and prevention of fraud waste, and abuse is a cooperative effort, involving all employees. All employees and network providers are required to cooperate in any investigation conducted by BBHC, DCF, Carisk, or law enforcement. BBHC receives fraud, waste and abuse and/or suspicious claim notification from the following sources:

- Tips from consumers, providers and the general public received by BBHC
- Incident reporting
- Complaints and Grievances
- Media reports
- Information obtained in conjunction with monitoring conducted by BBHC
- Office of Inspector General's (OIG) database of excluded individuals/ entities
- Referrals from the Florida Department of Children and Families, or other agencies engaged in identifying, investigating and prosecuting fraudulent activities.

3. Investigation

BBHC Investigation Procedures include, but are not limited to, the following:

- Conducting interviews, service validation, program review, report writing, and information disclosure;
- Processes when suspicious claim is identified;

- The suspicious billing indicators;
- The duties and functions of the Investigators.

Through the course of its investigations, BBHC/Carisk investigators may work with regulatory bodies (i.e. DCF SAMH Program office, AHCA, etc.) to review questionable billing and provide guidance. Activities include:

a) Assessing the quality and credibility of allegations or suspicious situations. Initial exposures and recovery potential are identified to determine if a case should be opened.
b) Cases are prioritized pursuant to commonly accepted business practices and business objectives, as well as potential jeopardy to consumers.
c) An investigative action plan/timeline is developed to guide the investigation. The action plan is periodically reviewed and revised as circumstances change.
d) Relevant billing data for the period in question is obtained and reviewed and evidence is gathered to support data analysis and allegations.
e) Observe what's happening via "ground-truthing". Ground truthing is a verification process that uses data gathered by direct observation to substantiate data gathered from secondary sources.
f) An investigative summary/report is prepared which summarizes the investigative findings, displays a comprehensive understanding of the facts and financial implications, and recommends a corrective action plan, if indicated, to include reporting as appropriate and follow-up. BBHC will submit copies of investigations to the Florida Department of Children and Families, SAMH Program Office, as indicated.

BBHC will conduct a preliminary investigation of a potential fraud, waste, or abuse case. This investigation methodology may include:

- Review of previous investigations or reports of fraud, waste, and abuse by the entity in question (subcontracted provider) with all information related to the previous investigation, the outcome of the investigation, and whether the new allegation is the same or related to a previous investigation, to determine any connection with the case under review;
- Subcontracted provider complaint logs;
- Reports of subcontracted provider paid billing, denied billing, and encounter data;
- Communication with consumers and subcontracted providers during the course of the investigation to confirm the alleged fraud, waste, or abuse activity and related provision of services;
- Annual Contract Monitoring Risk Assessment

Employees and Network Providers are required to submit requested information to BBHC based on BBHC's requested timeframe.

4. Non-Compliance

If compliance with the Audit process is not met, one or more of the following actions may be taken:

- Corrective Action Plan
- Recoupment of funds tied to the date span audited
- Report findings to credentialing, licensing, and public bodies and included in the

quarterly reconciliation reports submitted to DCF
- Review participation in BBHC network provider organization and for possible contract termination
- Report findings to BBHC and BBHC's Attorney for review of legal issues, and when necessary, the BBHC Board of Directors
- Human Resources to manage disciplinary process when internal BBHC/Carisk staff is involved
- All providers that do not comply with a BBHC audit will be reported to the Florida Department of Children and Families, SAMH Program Office.

C. Internal Fraud, Prevention, Detection, and Investigation

BBHC has adopted fraud prevention, detection, and investigation procedures for internal issues as above for the external issues.

II. RECOVERY

BBHC acknowledges its responsibility to be a proper steward and to ensure that only eligible consumers are afforded behavioral health services, only necessary and appropriate services are rendered, and that anti-fraud, waste, and abuse programs and procedures are in place. Additionally, BBHC acknowledges its responsibility to recoup overpayments to providers under contracts as a means of reducing unnecessary costs.

To this end, BBHC and Carisk utilize all available methods to detect improper billing and coding practices and employ competent investigators, data analysts, and other professionals to detect, remedy, and recoup identified overpayments. These recovery efforts are integral to the anti-fraud, waste, and abuse efforts of BBHC and supplement the other responses to such behaviors. In addition, immediate discovery will be reported to DCF SAMH.

A. Supported/Not Supported Fraudulent and Suspicious Billing Patterns

If the investigation supports fraudulent and/or suspicious billing patterns corrective actions are required and may include:
- Identification of inappropriate payments
- Notification to a provider of Monitoring Plan
- Requirement of Corrective Action Plan (CAP)
- Recommendation for Provider Education
- Updates to key BBHC/Carisk management staff, and, if indicated, the BBHC Board of Directors
- Notifying DCF and the OIG, as indicated, per CFOP 180-4
- Mandatory Reporting Requirements to the Office of Inspector General
- Documentation of findings at the conclusion of the investigation
- Confirmation that corrective actions are completed
- Contract suspension or termination

If the investigation does not support the allegations filed, the case findings will be documented for tracking/reporting purposes and future reference, and then closed.

All detailed information about the investigation is recorded in a separate and secure record accessible only to the BBHC/Carisk Management and is bound by the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Title II, 201-250.

B. Corrective Action Plan

BBHC/Carisk coordinates with providers to develop and implement one or more of the following, as indicated, as part of the Corrective Action Plans:

- Payment plan to recover overpayments
- Provider submission of a detailed Corrective Action Plan (CAP) to prevent recurrence
- Monitoring Program- The monitoring program may be for a six (6) month or twelve (12) month time period, as determined and involves additional audits to ensure adherence to the submitted CAP
- Provider education or technical assistance, as required

III. REPORTING

Pursuant to regulations, information regarding suspected fraud, waste, and abuse will be reported to the Florida Department of Children and Families SAMH Program Office, and when meeting criteria, reported to the Office of the Inspector General (OIG), (CFOP 180-4). All case files being referred will contain documentation that clearly defines and supports the allegation of suspicious activity, include detection, and reported dates.

A fraudulent act is committed if a person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, any written statement as part of, or in support of an invoice for services, which the person knows to contain materially false information concerning any material fact. Also, a fraudulent act is committed if the person conceals, for the purpose of misleading another, information concerning any material fact.

BBHC/Carisk shall cooperate fully with the Florida Department of Children and Families SAMH Program Office, and/ or other law enforcement agencies, as appropriate, in their prosecution or additional investigation of cases reported on behalf of BBHC.

A log of all incidences of suspected fraud, waste, and abuse received by BBHC, regardless of the source, will be maintained. All information to support fraud, waste and abuse cases will also be logged. This log may contain:

1. The subject of the violation
2. Source of the allegation
3. The date the allegation was received
4. Provider name and contract number
5. The date that suspected fraudulent activity is detected
6. The date that reports of such suspected fraud are sent directly to the Department Program Office and OIG
7. Status of the investigation

IV. EDUCATION AND TRAINING

A. Education and Fraud, Waste, and Abuse Awareness

Anti-fraud education of staff and subcontracted network service providers is mandatory. The intent is to address fraud, waste, and abuse, and potential impact.

Each employee plays a key role in the eradication of fraud, waste and abuse committed against BBHC and its stakeholders. BBHC employees report any suspected incidents of fraud, waste and abuse to the BBHC Director of Administration and any other member of the Manager.

B. Provider Education

Upon contracting with BBHC, Contract Management will schedule an orientation with the provider to go over the contract requirements, including Fraud, Waste, and Abuse Plan. Documentation of this is recorded in the Contract Manager's file.

The Fraud, Waste and Abuse Plan will be available to the provider network. BBHC requires all subcontracted providers maintain a fraud; waste and abuse plan and affirm the responsibility of the provider to report all cases of suspected fraud, waste, and abuse. All subcontracted providers and agents are required to provide fraud, waste, and abuse training to their staff.

V. PRIMARY CONTACT PERSON

The personnel identified herein should be extended immunity from civil liability concerning the sharing of information regarding persons suspected of committing fraudulent acts with Anti-Fraud personnel employed by other related entities. Any inquiries regarding the BBHC Anti-Fraud Plan should be directed to:

BBHC's Director of Administration
Broward Behavioral Health Coalition
3521 West Broward Blvd.
Suite #206
Lauderhill, FL 33312
(954) 622-8121 Office

Responding to DCF Inquiries

BBHC's Director of Administration is the primary contact for all related inquiries and ensures that BBHC cooperates fully with any Florida Department of Children and Families investigation.

Whistleblower Protection and Non-Retaliation policy

1. BBHC complies with all state and federal requirements for government-sponsored programs, including the Federal False Claims Act, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, applicable Whistleblower Protection laws, and any state false claims statutes.

2. BBHC does not retaliate against an employee for reporting or bringing a civil suit for a possible False Claims Act violation. BBHC does not discriminate against an employee in the terms or conditions of his/her employment because the employee initiated or otherwise assisted in a False Claims Act action.

3. BBHC does not retaliate against any of its subcontracted providers for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority.

4. Federal and state law also prohibits BBHC from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a False Claims Act action.