Title : **Fraud, Waste and Abuse (FWA) Prevention and Detection**		Policy Number: **MA- C 0004**
Originating Department: **Compliance**	Affected Department: **See Required Distribution List**	
Department Director Approval: **Erin K. Heckethorn, Dir. Compliance & Product Management**	Original Date: 01-2013 Revised Date: 04-2016 Reviewed Date: 03-2018	President Approval: **F. Craig Humphrey, FCC President**

STANDARD (S): Medicare Managed Care Manual, Chapters 9 & 21

42 C.F.R. §§422.503 and 42 C.F.R. §§423.504

31 U.S.C. §§ 3729-3733 False Claims Act

42 USC § 1395 Stark Law

42 USC § 1320a – 7(b) Anti-Kickback Statute

Policy: Pursuant to CMS regulations, a Medicare Advantage organization should "adopt and implement an effective compliance program, which must include measures that prevent, detect and correct non-compliance and that prevent, detect and correct fraud, waste and abuse.

Purpose: To describe FirstCarolinaCare Insurance Company's (FCC)'s process for ensuring that employees, contractors, agents receive information about Fraud, Waste and Abuse (FWA) detection and prevention related to federal health care programs.

REQUIRED DISTRIBUTION LIST

☒ All FCC Employees

☒ CEO / COO

☒ Medical Director

☒ Compliance Department

☒ Finance Department

☒ Health Services Department

☒ Provider Relations & Credentialing

☒ Medicare Operations

☒ Part D &Pharmacy Department

☐ FirstHealth of the Carolinas/Related Entities

☒ FDRs / Delegate(s)

☒ Board of Trustees

Definitions

1. ***Fraud-*** As defined by the Centers for Medicare and Medicaid Services (CMS), it is the intentional deception or misrepresentation made by an individual who knows that the false information reported could result in an unauthorized benefit to him or herself or another person.
   Fraud can be committed by beneficiaries, pharmacies, providers, health plans, first tier or downstream entity, sales agents /brokers or by any combination of the above.

2. ***Waste*** – the inappropriate utilization and /or inefficient use of resources.

3. ***Abuse-*** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Advantage Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

4. ***CMS Medicare Drug Integrity Contractor*** (**MEDIC**) - An organization that CMS has contracted with to perform specific program functions. Its primary role is to identify and investigate potential Fraud, Waste and Abuse (FWA) in Medicare Parts C&D Programs.

PROCEDURES

Detecting and preventing Fraud Waste and Abuse (FWA) is the responsibility of everyone affiliated with FCC's Medicare Advantage product, including employees, members, providers, vendors and agent/brokers. FCC's Compliance Program strives to improve the quality, productivity and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including reducing FWA. FCC is committed to meeting rigorous compliance requirements by specifically:

- Providing a mechanism that brings the employees, providers and members together to reach mutual goals of reducing fraud and abuse;

- Educating employees, providers, and members regarding beneficial practices in the prevention, detection, measurement, enforcement, and reporting of potential fraud and abuse;

- Strengthening awareness of compliance to all appropriate departments and business partners, and provide oversight and guidance in the prevention, detection, enforcement, and reporting of potential fraud and abuse;

- Enhancing existing and developing new internal controls to assure compliance with regulatory and internal guidelines;

- Enhancing the communications system to encourage employees, members, and business partners to report suspected misconduct;

- Reacting quickly and accurately to reports of potential fraud and abuse, effectively target resources to address those reports;

- Assessing employee and contractor behavior relating to fraud and abuse in order to develop performance improvement plans that will strengthen knowledge of compliance and correct inappropriate performance behaviors; and

- Utilizing fraud and abuse resources to specifically target the inclusion, but not limited to, embezzlement & theft, underutilization, double billing and improper coding for prevention, detection, measurement, enforcement, and reporting of potential fraud and abuse.

I. Important Federal Laws Relating to Healthcare Fraud, Waste and Abuse

FCC is committed to complying with all applicable statutes, regulations and other contractual requirements related to the delivery of its Parts C and D benefits, including but not limited to the following:

A. *Federal False Claims Act* (FCA) *31 U.S.C. Title 3729* – the FCA imposes civil liability on any person who –

- Knowingly submits or causes the submission of a false or fraudulent claim to the federal government for payment or approval.
- Knowingly makes or uses a false record or statement OR causes one to be made to be made or used for the purpose of getting a false/fraudulent claim to be paid or approved by the government.
- Conspires to defraud the government by enabling the approval or payment of a false or fraudulent claim.
- Knowingly makes or uses a false record or statement to conceal, avoid or decrease an obligation to pay money or transmit money to the government.
- Has actual knowledge of the information.
- Acts with either reckless disregard or with deliberate ignorance of the truth or falsity of such information. No proof of specific intent to defraud the federal government is required.

The FCA imposes two types of liabilities:

(i) Civil penalty for the submitter of the false claim or statement , regardless of whether the submission of the claim causes any damages or if the claim is rejected and

(ii) Penalties for any monetary damages that the government sustains due to the submission.

Under the FCA, anyone who knowingly submits or causes the submission of false claims is liable for three times the government's damages plus civil penalties ranging from $5,000 to $10,000 per false claim.

B. *Whistleblower (Qui Tam) Protection*- This provision protects employees who assist the federal government in the investigation and prosecution of FCA violations. This protection only applies to actions taken with regards to a viable false claims act case and prevents an employee from any retaliatory acts such as termination or harassment. If any retaliation occurs, the employee has a right to obtain legal counsel to defend the actions taken against him/her.

C. *Physician Self-Referral Prohibition Statute* ("Stark Law") *42 U.S.C 1395*- this statute prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applied. It also prohibits an entity from presenting or causing to be presented a claim to anyone for a DHS furnished as a result of a prohibited referral.

D. *Anti-Kickback Statute* (AKS) *42 U.S.C. 1320a-7b*: this statute applies to Medicare and Medicaid and prohibits healthcare professionals, entities and vendors from knowingly offering, paying, soliciting or receiving remuneration to induce the referral of federal healthcare program business. Remuneration includes the transfer of anything of value, directly or indirectly, or in cash or kind. Violators of this statute are subject to criminal sanctions including imprisonment, high fines and exclusion from Medicare/Medicaid. Federal regulations also include "safe harbors" that protect certain technically prohibited activities from prosecution.

E. *Antitrust Laws* – State and Federal antitrust laws prohibit monopolistic conduct that restrains trade.

F. *Health Insurance Portability and Accountability Act of 1996* (HIPAA) *45 CFR 160 & 164* – HIPAA was enacted to improve the efficiency and effectiveness of health information systems by establishing standards and requirements for electronic transmission of certain health information held by covered entities, including plan sponsors. The protection of individual information may decrease chances of fraudulent misuse of such information and decrease the risk of identity theft.

G. *Patient Protection and Affordable Care Act of 2010* (PPACA)

H. *Federal Regulations for the Medicare Program*

I. *Regulatory guidance issued by CMS for MA and MAPD programs such as manuals, memoranda, training materials and guides.*

J. *Applicable State laws and regulations*

K. *Contractual terms and conditions.*

II. Types of Fraud, Waste and Abuse

According to CMS regulations, there are several areas perceived to be prone to a high level of fraud and abuse in a Medicare managed care setting including – benefit design, enrollment / post-enrollment activities, marketing activities, claims processing, over/under

utilization, data collection and submission, formulary development, drug pricing and rebates and FDR (Vendor) activities.

Types of healthcare fraud, waste and abuse include but are not limited to the following categories:

A. Health Plan Fraud
- Failure to provide medically necessary services
- Improper bid submissions
- Payment for excluded drugs
- Multiple billing
- Inappropriate formulary decisions
- Inappropriate enrollment/disenrollment activities
- Falsification of financial solvency
- Improper cost reporting or cost shifting
- Inappropriate physician incentive plans
- Providing data to CMS that lacks integrity
- Double billing
- Identity Theft
- Improper member coordination of benefits
- TrOOP (Member True-out-of-pocket costs) or LIS (Low Income Subsidy) manipulation

B. Agent/ Broker and Marketing Fraud
- False advertising
- Falsifying individual information on Medicare enrollment forms
- Misrepresentation of plan benefits
- Member signature forgery for enrollment purposes
- Advising beneficiaries to enroll in a plan they do not need

C. Member Fraud
- Failure to disclose other health coverage
- Misrepresentation of medical condition
- Provision of false information on enrollment form
- Using another person's Medicare card/ information to obtain services
- Colluding with provider to bill for services not rendered
- Submission of false claims
- Doctor shopping
- Identity theft
- Prescription forgery or alteration
- Prescription stockpiling

D. Provider Fraud
- Billing for services not rendered or "free" services
- Receiving compensation for writing prescriptions or services
- Provision of unnecessary care

- Incorrect billing / coding practices
- Provision of fraudulent diagnoses

E. Pharmacy Fraud
- Billing for brand drugs when generics are dispensed
- Billing multiple payors for the same prescriptions
- Dispensing expired or adulterated drugs
- Forging or altering prescriptions
- Refilling prescriptions in error
- Failure to offer negotiated prices
- Prescription drug shorting
- Bait and switch pricing

F. Claims Processing and Third Party Vendor Fraud
- Upcoding (using codes that pay at a higher rate)
- Improper bundling / unbundling of claims
- Submission of duplicate claims
- Misrepresentation of claims information
- Billing for an invalid number of units
- Billing for out-patient services where member is an in-patient facility

III. FCC's Fraud, Waste and Abuse Plan

FCC believes that preventing, detecting and reporting FWA is everyone's responsibility. Its FWA Program, as administered by the Compliance department, is a subset of the overall Compliance Plan designed to deter, identify, investigate and resolve potential fraudulent activities that may occur in its daily operations, either internally or externally.

The Compliance Officer is responsible for ensuring that the objectives of the FWA program are carried out in a timely and effective manner. Department Directors and senior managers are also responsible for implementing internal quality control measures they deem necessary to ensure that their processes do not violate FWA requirements and must identify and report any such issues within their department in a timely manner.

A. Elements of the Plan

All components of FWA prevention activities at FCC are integrated into each of the seven elements of an effective compliance program. The following sections details each of these elements and how FCC addresses them in relation to FWA prevention.

1. Written FWA Policies and Procedures, and Standards of Conduct: FCC maintains policies and procedures that clearly states its commitment to comply with all applicable federal, state and Medicare regulatory requirements. These detailed and readily accessible policies describe FCC's expectations of compliance with all regulatory requirements and

can be referenced to better understand the overall fraud, waste and abuse process. Relevant policies include but are not limited to the following:

MA-C 0008 Conflict of Interest
MA-C 0037 Code of Ethical Conduct
MA-C 0221 OIG/GSA Screening Policy
MA-C 0040 Issue Identification and Follow-Up
MA-C 0220 FDR Oversight – Annual Risk Assessment
MA-C 0038 Communication of CMS Regulation and Changes
MA-C 0047 General Medicare Contracting and Delegation Oversight Requirements
MA-C 009 Corporate Commitment to Compliance
MA-C 0036 Medicare Training
MA-C 0051 Compliance Communication Reporting
MA-C 0042 Disciplinary Counseling
HP-101 TO HP-507 HIPAA Policies and Procedures

2. Compliance Officer, Committee and High-Level Oversight:

(a) *Compliance Officer (CO)* – FCC's CO is responsible for the overall development, operation and monitoring of the FWA Program. This position is independent and allows the freedom to raise FWA issues and report them directly to the President, Compliance Committee or Board of Trustees. It also allows the Compliance Officer to seek the advice of legal counsel, as needed.

To accomplish the goals of the FWA Program, the CO designates and oversees the performance of the following functions within the compliance department:

- Development and administration of training programs to educate staff, providers, members, FDRs and board members on preventing and detecting fraud, waste and abuse.
- Development and implementation of communication systems that encourage management and employees to report FWA violations without fear of retaliation.
- Identification, detection, investigation and resolution of all suspected instances of FWA, both internally and externally.
- Cooperation with appropriate government and law enforcement agencies in the referral and reporting of suspected/actual fraud, waste and abuse.

(b) *Compliance Committee (CC*)- specific responsibilities of the compliance committee include:

- Providing oversight and direction to FCC's Compliance department.
- Receiving and analyzing reports regarding FWA trends and schemes, legal requirements and specific risks related to FCC's operational processes.
- Working with applicable departments and providers to develop and implement FWA-related policies and procedures.
- Determining appropriate strategies for promoting compliance with FWA requirements and detecting potential violations.
- Developing a system to solicit, evaluate and respond to potential FWA issues.
- Assisting with the development of internal systems and controls
- Assisting with investigation and implementing of corrective actions.

- Training and educating staff on FWA issues and approving educational materials before use.
- Assisting the CO in deciding whether disciplinary action is warranted in minor FWA cases.

NOTE: FCC's compliance officer does not necessarily wait for approval by the compliance committee to implement FWA actions and/or activities, but must report all activities actions taken at the next scheduled committee meeting.

3. Effective FWA Training and Education

FCC strongly believes that all employees, members, providers, board members, agent/brokers and FDRs must be trained in detecting and reporting reasonably suspected FWA incidents.

- *General Training* - training related to the administration and operation of the Medicare Advantage program and FWA education is provided within 90 days of hire and annually thereafter. FCC uses its document management system, PowerDMS, to assign, monitor and track all training.

- *Specialized Training*- FCC, through PowerDMS, also provides in-depth FWA education and materials on FWA that is specific to operational areas, such as Claims, Enrollment, Finance, Health Services, Member Services, Pharmacy and Sales & Marketing. These job-specific training materials will eventually be assigned to each department for annual completion. Examples of FWA training materials available in PowerDMS include:

  (i) CMS National Training Program: "Medicare and Medicaid Fraud and Abuse Prevention"
  (ii) Medicare Advantage and Part D Program Integrity Basics"
  (iii) "Medicare Advantage and Part D Fraud Handbook: Practical Techniques and Approached on Detecting and Preventing Fraud"

- *Ad Hoc Training*- FCC creates and maintains specialized internal training materials developed in response to risk assessments, changes to the Medicare Program, corrective actions or by request.

- *FDR Training*- FCC contracts with first tier, downstream and related entities (FDRs) that meet CMS' FWA certification requirements or are exempt as a DMEPOS provider or supplier. The Compliance department requires that all its FDRs complete annual FWA training via CMS' Medicare Learning Network and to provide a signed attestation signifying completion.

  In addition, all FWA-related policies and procedures are available for review by FCC FDRs on the company website. These policies provide information on how to identify and report FWA and FCC's expectations for reporting FWA, which includes assisting with the resolution of these issues in a timely and consistent manner.

- *Agent/ Broker Training*- FCC Agents and Brokers are categorized as FDRs and are hence subject to the FWA training requirements mandated by CMS. All agents and brokers receive training on FWA as part of the compliance training that must be completed upon hire and before FCC's Annual Enrollment Period (AEP) each year.

4. Effective Lines of FWA Communication

Communications, both to and from FCC's Compliance department are key to the effectiveness of its FWA program. The Compliance Department communicates FWA information, including current trends/ schemes, fraud alerts or identified persons or entities that have participated in fraudulent activities to the appropriate operational departments and FDRs.

(a) **Monitoring Communications**- the Compliance department regularly monitors information about FWA from CMS Fraud Alerts, CMS' O& E MEDIC website, updated CMS manuals, HPMS memoranda, PBM-issued monthly FWA newsletters, member grievances and CTMs.

(b) **Clarifications and Interpretations**- FCC employees are encouraged to ask questions about scenarios that may give rise to FWA issues.

(c) **FWA Reporting**- FCC requires any employee of FDRs who suspects inappropriate FWA behavior to report the suspicion to the Compliance Department. FWA reporting can be done by telephone, email, or mail. Employees and Business Partners may also use the Compliance Hotline at **1-855-367-8184** for anonymous reporting of any suspected FWA. The Compliance Department also formally reports any confirmed FWA to the designated federal agencies, including the Medicare Drug Integrity Contractor (MEDIC) and law enforcement.

(d) **FWA Tracking**- the Compliance Department receives, maintains and disseminates information and regulatory alerts to all applicable departments and FDRs. Grievances, both oral and written are analyzed for potential FWA risks and documented to study possible trends and schemes. Complaints received via CMS' Complaint Tracking Module (CTMs) that involve potential FWA, misconduct, sales or marketing allegations are forwarded to the appropriate department for investigation and resolution.

FCC also has a well-documentation policy of non-retaliation toward any person who reports a potential or observed violation (See MA-C 0007).

5. Well-Publicized FWA Disciplinary Standards- FCC enforces its compliance and ethical standards through well-publicized guidelines that reflect clear and specific policies and the consequences of violating FCC's Code of Ethical Conduct (COEC).

These policies are made available to all employees and FDRs upon hire and annually via PowerDMS. All employees are advised that disciplinary action may be appropriate where he/she fails to detect a violation, either through negligent conduct.

Intentional or reckless noncompliance is subject to significant disciplinary action, including termination. Disciplinary actions range from verbal warnings or re-training and can lead to suspension or termination, as deemed appropriate by the situation.

FCC also includes a provision in its contract with providers and other FDRs stating that violations may result in termination of the contractual relationship.

Employing and Contracting with Excluded Individuals/Entities*:* aside from the civil and criminal actions brought by law enforcement agencies for violation of laws in Section I, the Medicare program has additional administrative remedies for FWA violations. Under the Exclusion statute, the Office of Inspector General (OIG) excludes from participation in all federal health care programs any provider, individual or entity convicted of:

- Medicare fraud
- Patient Abuse or neglect
- Felony convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct related to delivery of a healthcare item or service
- Felony convictions for unlawful manufacture, distribution, prescription or dispensing of controlled substances.

FCC screens all Staff and Business Partners, including new employees, temporary employees, volunteers, consultants and board members monthly to verify that they do not appear in any of the federal government databases that house these exclusions.

FCC also requires its FDRs to screen all of their employees and downstream entities monthly through the exclusion databases and/or any additional lists required by government programs. FDRs are required to attest to conducting monthly screenings on an annual basis and to provide documentation of regular screening samples to FCC upon request.

6. Effective System for Routine Monitoring, Auditing and Identification of FWA Risks - FCC's FWA auditing and monitoring processes incorporate requirements of the Medicare Advantage program as indicated by:

(a) Annual Risk Assessment: the Compliance department, with the approval of the Compliance Committee, conducts an annual risk assessment of all operational areas that addresses risks posed both by non-compliance with CMS Part C and D requirements or that may constitute fraud, waste or abuse.

The results of this assessment are ranked according to magnitude of risk and the corresponding FDR to whom that function is delegated. This process determines the types of monitoring reviews and internal audits to be performed by FCC during each calendar year, as documented in its Annual Compliance Calendar. This routine process takes into account:

- Program areas identified in the annual Office of Inspector General (OIG) work plan.
- Policies and Procedures implemented as a result of internal and external FWA actions or plan audits.

- Internal and external Corrective Action Plans
- New/Revised requests from regulatory agencies or internal operational changes
- CMS and other agency fraud alerts
- Changes made to the Medicare Managed Care or Prescription Drug Benefit Manuals issued by CMS.
- Referrals from all internal FCC departments (e.g. corrective action plans, claims, customer services, grievances and appeals, member complaints and pharmacy audit findings)
- Industry literature and vendor newsletters
- CMS Audit findings
- Results of prior monitoring / auditing reviews conducted by FCC or its FDRs.

(b) Routine Monitoring: After conducting the annual risk assessment, the Compliance department develops an auditing and monitoring work plan that, at a minimum, addresses issues identified as high risk in the risk assessment. FCC also uses this work plan to identify, initiate and develop monitoring reviews.

Monitoring reviews help ensure that all departments are in compliance with MA and PD program requirements and FCC policies and procedures. These reviews also evaluate the performance of FCC's Compliance program in several other areas, including-

- Review of training requirements
- Monitoring Call Center trends
- Grievances and member complaints that raise potential FWA concerns
- Delegation Oversight activities
- Effectiveness of reporting mechanisms
- Potential sanctions screenings
- Compliance with HIPAA requirements
- Record retention

FCC also monitors FDRs and contracted providers for compliance with regulatory requirements and contractual obligations as stated in Chapters 9 and 21 of the Medicare Managed Care Manuals. Routine monitoring reviews are included as part of FCC's contractual agreement with vendors and providers. Results of these reviews identify potential contractual or compliance corrective actions.

Results of monitoring reviews are summarized in a standard report that outlines the review's objective, scope and methodology, recommendations and findings. The corrective actions required to respond to findings are documented according to FCC processes and shared with the Compliance Committee and Board of Trustees on a quarterly basis.

(c) Internal Auditing: FCC conducts a combination of internal and on-site audits documented in its work plan. Based on the results of the annual risk assessment, activities are selected from follow-up audits on previous areas on non-compliance, corrective action plans (CAPs) or other activities selected from FCC's monitoring plan and approved by the Compliance Officer.

The audit work plan details:

- the specific type of audit to be performed
- audit schedule, including start and end date
- audit methodology
- resources to be committed
- type of audit (desk or onsite)
- person responsible for conducting the audit
- final audit report due date to Compliance Officer
- follow-up activities from audit findings

(d) Compliance Effectiveness Audits: On an annual basis, the effectiveness of FCC's Compliance and FWA Programs are audited by an external entity that has the appropriate expertise to assess CMS program requirements and provide recommendations for improvement.

7. Procedures and Systems for Prompt Response to FWA Issues - FCC's Compliance department, headed by its Compliance Officer, has established procedures for promptly responding to FWA issues as they are raised, investigating potential violations as identified via self-evaluations, reporting or auditing and monitoring activities and reducing the likelihood of recurrence, while ensuring continued compliance with State and Federal requirements.

(a) *Inquiry and Investigation*: the Compliance department conducts a timely and well-documented reasonable inquiry into any potential FWA violation. The investigation will be conducted no later than two weeks after the date the potential incident is reported or identified.
- an inquiry is deemed to be initiated once recorded in FCC's FWA Tracking log
- all inquiries will be conducted by the Compliance Officer or his/her designee
- the integrity of the investigation is preserved by securing all relevant documents and minimizing the number of staff working on the case.
- investigation efforts will include but are not limited to:
  (i) documentation of all relevant information,
  (ii) review of regulatory guidance,
  (iii) communication with any affected parties,
  (iv) data analysis of the issue and
  (v) discussion with executive management and compliance committee members, if relevant

(b) *Corrective Action Plan*: in the event that an actual violation has been identified, upon completion of the investigation, the Compliance department will initiate a Corrective Action Plan (CAP). The CAP is designed to correct the underlying problem(s) that resulted in the violation and to prevent future noncompliance. The CAP also set specific timeframes for completion of actions towards addressing the deficiencies.

Follow-up action is also performed on all CAPs (by monitoring) to ensure that the misconduct has been addressed. Where corrective actions are not properly implemented or the misconduct still continues, additional disciplinary measures, including and up to termination of the employee or FDR may be considered.

(c) *Self-Reporting to Regulatory Authorities*: If after conducting a reasonable inquiry, the Compliance
Department determines that fraud, waste or abuse has occurred, the conduct is referred to the CMS NBI MEDIC offices promptly, but no later than sixty (60) days from the date of the determination. To the extent that such conduct involves an FCC FDR, the referral will be made sooner to assist CMS with identification of other instances of the wrongful conduct.

For each FWA referred to the NBI MEDIC, FCC will provide the following:

- Provider Name (if applicable)
- All known billing and tax identification numbers and addresses
- Type of item or service involved in the allegation
- Place and Date of Service
- Description of the allegation
- Detailed description of all investigations conducted by FCC during its investigation process
- Name, HICN, addresses and contact information of any impacted beneficiaries
- Contact information of FCC employee or vendor who received the complaint
- All documents relating to prior sanctions and/or compliance corrective actions taken, if any.

(d) *Record Retention*: FCC will maintain files for a period of ten (10) years on all providers or affiliates who have been the subject of complaints, investigations, violations and prosecutions. FCC also maintains files that contain documented warnings, results of previous investigations and complaints that result in investigations. FCC will comply with requests by law enforcement, CMS or any of its designees regarding monitoring of providers within its network that have been identified as potentially abusive or fraudulent.

APPENDIX A – Specific FCC Fraud, Waste and Abuse Activities by Department

1. Part D and Pharmacy

FCC's Compliance and Pharmacy departments work with MedImpact (Plan PBM) to provide ongoing oversight of the Part FWA prevention program. MedImpact (MI) utilizes a vendor to review claim activity and to conduct onsite pharmacy audits. FCC's PBM also uses software, which is a combination of relational database, predictive modeling and highly developed algorithms to review claims and is designed to:

- Audit Claims
- Deter, identify and recover fraudulent claims submission
- Identify recoveries
- Protect the financial integrity of the prescription benefit program
- Identify areas of concern and potential problems

Prescriptions that require further inspection are identified for either a desktop or onsite audit and audit activity reports are provided for each Plan. The vendor selects pharmacies for onsite audits and inspects prescriptions monthly as part of the comprehensive site review process.

(a) **Desk Top Audits** – MedImpact's audit department conducts a complete analysis of pharmacy provider prescription claims. It utilizes 100% of the claims that process through its Central Claims system. Data is analyzed and reviewed using approximately 90 edits to find patterns, anomalies, errors and potentially fraudulent activity that is designed to detect medication waste.

(b) **Onsite Audits**- MI's on-site audit program is a general overview and examination of the pharmacy's practices, procedures and general facility. Performed by pharmacy professionals, on-site audits are designed to enhance program compliance and provide a watchdog effect to deter fraudulent and deviant behavior.

The onsite audit is also used to capture credentialing information. Auditors will note such items such as counseling availability, hours of operation, languages spoken by staff and other special services provided, wholesalers used and other quality-related issues.
The onsite review program also provides overpayment and fraud activity review. This is performed by utilizing a suite of edits to automatically select, rank and score pharmacies across over 50 distinct criteria. The use of predictive modeling. Techniques as well as proprietary "fraud formulary" help identify not only individual stores for review, but specific prescriptions that may be worthy of actual inspection.

- *Selection*: MI generates various summary reports to statistically identify pharmacies that deviate from normal plan percentages. Through these specialized reports, which are incorporated into a ranking report card, the PBM selects a number of pharmacies to conduct onsite reviews. This selection process increases the odds of detecting fraudulent activity. Additional pharmacies may be selected as a result of state or client referral, patient, physician or peer complaints.

- *Preparation and Visit*: Prior to visiting a pharmacy for an onsite audit, MI or its designee schedules an appointment with the Pharmacy Owner/Manager and may even make an

arrangement with its corporate office to have a Regional/District Manager present for the audit. In preparing for the review, targeted prescriptions and patient records are selected prior to arrival. During all onsite visits, auditors collect information and claims selected for the audit are scanned and stored securely.

Examples of Fraud, Waste and Abuse Criteria used by MedImpact

- High dollar claims
- Unusual high quantities
- Unusual day's supply
- Excessive claims for controlled substances
- Brand use percent
- Controlled substance dispensing or prescribing percent
- Excessive rejections
- High dollar or prescription volume for pharmacies or physicians
- Unusual package size items
- Less Frequently-billed items
- Items requiring special and/or restricted protocols
- Duplicate/Double billing
- Early Refills
- Refills outside State or Federal allowances (high /excessive number of refills)
- Incorrect quantity for day's supply
- High Dispense-As-Written (DAW) percent
- Use of terminated NDCs
- Billing incorrect package size
- Physicians billing outside specialty
- Failure of physician ID validation for controlled substances
- High member utilization
- High compound percent
- High $$$ compound claims
- Appearance of split billing to increase fees or bypass early refill edits
- High percent of Prior Authorization overrides
- Billing during periods when the pharmacy is closed, after hours or holidays
- Excessive referral rates
- High cost injectables
- Refill patterns
- DUR interactions
- Invalid or terminated DEA or license numbers
- Infusion medications per member

Other variables reviewed when examining hard copy prescriptions:

- Completeness of prescription
- Member and physician information
- Medication description
- Directions for use

- Refill directions
- DAW information

- Notes (PA, Additional refill information, etc.)

2. Sales and Marketing

FCC's Compliance department works closely with its Agent/Brokers and Account Managers to identify and prevent FWA.

- All agents are trained by the Compliance department or through the use of CMS-approved training materials.
- Only CMS-approved marketing materials are used
- Audit of agents and brokers prior to hire and monthly to verify licensure and non-inclusion of OIG and SAM websites
- Random check of actual marketing materials used for member meetings
- Surprise/secret visits to seminar presentations
- Rapid disenrollment rate and cancellation rate analysis
- Member complaints on agents received from customer service reps, CTMs and grievance department logs are tracked and monitored for possible trends.

3. Claims Processing

FCC has proactively added the following edits in its claims system to ensure FWA is prevented and detected:

- Invalid Diagnosis codes
- Invalid Procedure codes
- CPT / Place of Service mismatch
- Invalid CPT /modifier combination
- Excessive invalid units
- Incorrect bill types
- Duplicate services
- 3 day/ 1 day payment window