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Service Center/Operating Unit: Texas	Subject: Texas PSD Healthcare Claims Fraud & Abuse Investigations	
Approval Signatures:		
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- I. Reports related to the Texas Medicaid/CHIP program will comply with both S103 and this addendum. Conflicts between the two documents will be addressed in a manner that complies with applicable Texas laws and regulations
 - A. Reporting and Communication
 1. Notice of Policy and/or Procedure changes will be provided through the TX PSD Committee structure to include the following:
 - a) Changes to National ValueOptions Compliance Policies and Procedures are provided on a monthly basis through the National Compliance Work Group, which the Texas PSD Compliance Officer attends. Urgent updates will be communicated via ad hoc meetings and/or written notice.
 - b) Changes to Texas PSD and/or National Policies and Procedures will be reviewed at Texas PSD Senior Management Clinical and Operations Committee (CLOPS) informal weekly meeting. Any changes affecting the Texas PSD Compliance Program will be referred and reviewed at the monthly Contract Review Committee. If necessary ad hoc meetings and/or written notice may be used to ensure updates to policies and procedures are communicated to affected areas within 20 working days of the change.
 2. Officers, directors, managers and employees must report possible waste, abuse and/or fraud within 24-hours of becoming aware of the issue.

- B. Allegations of Provider waste, fraud and/or abuse
 - 1. Initial Review/Preliminary Investigation will be completed within 15 days of the identification and/or reporting of suspected and/or potential waste, abuse or fraud.
 - 2. Investigation
 - a) Within 15 days of completing an Initial Review that results in an Investigation, the SIU Investigator will select a sample of at least 50 recipients or 15% (to be determined by the investigator) of a provider's claims related to waste, abuse and fraud.
 - b) The Investigator will review the requested medical records and encounter data within 45 working days of receipt of the records. The Investigator may request an extension from the HHSC-OIG if additional time is needed to complete investigations involving high volume providers.
 - c) Failure of a provider to supply requested records will result in the provider being reported to the HHSC-OIG as refusing to supply records upon request and may subject the provider to sanction or immediate payment hold.
- C. Allegations of Member/Recipient waste, abuse and fraud
 - 1. Claims will be reviewed to identify and prevent Member/Recipient waste, abuse or fraud and will include the following:
 - (1) Treatment(s) and/or medication(s) prescribed by more than one provider appear to be duplicative, excessive or contraindicated;
 - (2) Recipients are using more than one physician to obtain similar treatments and/or medication;
 - (3) Providers other than the assigned Primary Care Provider (PCP) are treating the recipient, and there is no evidence that the recipient was treated by the assigned PCP for a similar or related condition;
 - (4) The recipient has a high volume of emergency room visits with a non-emergent diagnosis;
 - b) Medical records for the recipient in question may be reviewed if the claims review does not clearly determine if waste, abuse or fraud has occurred.
 - c) Reports and edits will be used to identify possible overuse and/or abuse of psychotropic and/or controlled medications by recipients who are allegedly treated at least monthly by two or more

physicians (including psychiatrists, pain management specialists, anesthesiologists, physical medicine and rehabilitation specialists).

2. Initial Review/Preliminary Investigation of alleged Member/Recipient waste, abuse and/or fraud will be conducted with 15 days of identification and/or reporting of an allegation and include review of the following:
 - a) Review of acute care and emergency room claims submitted by providers for the suspected recipient.
 - b) Analysis of pharmacy claim data submitted by providers for the suspected recipient to determine possible abuse of controlled or non-controlled medications. In the event the pharmacy claims data is not available, the Investigator will request the data 15 working days of the initial identification and/or reporting of the suspected or potential waste, abuse or fraud.
 - c) Analysis of claims submitted by providers to determine if the diagnosis is appropriate for the medications prescribed.

D. Reporting to HHSC-OIG

1. The ValueOptions Texas PSD Compliance Officer is responsible for and has the authority to report all investigations of possible waste, abuse or fraud by provider and/or recipients which are required to be reported to the HHSC-OIG. The name, title, address, telephone number and fax number of the Texas PSD Compliance Officer will be provided to the HHSC-OIG within 15 working days of any changes.
2. The Director of SIU will notify the Texas PSD Compliance Officer within 15 days working days of determining possible waste, abuse and/or fraud has occurred. The report will include the information necessary for the Texas PSD Compliance Officer to meet their reporting obligation to HHSC-OIG.
3. The Texas PSD Compliance Officer will report/refer all possible acts of waste, abuse and fraud to the HHSC-OIG utilizing the HHSC-OIG fraud referral form and include the following:
 - a) Investigation report
 - b) Identification of the allegation and statutes/regulations violated or considered
 - c) The results of the investigation, copies of program rules and regulations violated for the time period in question and the estimated overpayment

- d) A summary of interviews conducted, the encounter data submitted by the provider for the time period in question, and all supporting documentation obtained as the result of the investigation.
- 4. Expedited Referrals: If the Texas PSD Compliance Officer reasonably believes delay in reporting may result in harm or death consumers, loss destruction or alteration of valuable evidence, poses a potential for significant monetary loss that may not be recoverable, or may result in hindrance of an investigation or criminal prosecution of the alleged offense, the TX PSD Compliance Officer will expedite the referral to the HHSC-OIG.
- 5. Quarterly Reports:
 - a) On a quarterly basis, the Texas PSD Compliance Officer will submit to HHSC-OIG a report of all investigations conducted that did not result in findings of waste, abuse or fraud. The report will include the following:
 - (1) The allegation
 - (2) The Medicaid number of the suspected provider or recipient
 - (3) The source of the allegation
 - (4) The time period in question
 - (5) Date the issue was identified or reported
 - b) A log of all investigations will be available to the HHSC-OIG upon reasonable request.
 - c) A log of all MCO training pertaining to waste, abuse and/or fraud in Medicaid / CHIP meeting the specifications outlined in the TAC will be made available upon request.
 - d) Record Retention: All records obtained as the result of an investigation conducted by SIU will be retained in compliance with ValueOptions Policies and Procedures, but not less than 5 years or until all audit questions, appealed hearings, investigations or court cases are resolved.