Title:	Fraud, Waste, and Abuse Detection and Investigation				
Department/Line of Business:	Compliance/Special Investigations Unit (SIU) Department / All lines of business				
Approver(s):	VP, Compliance / Fraud, Waste, Abuse Committee				
Location/Region/Division:	Scott and White Health Plan (SWHP)				
Document Number:	SWHP.CMP.086.P				
Effective Date:	11/04/2019	**Last Review/ Revision Date:**	11/04/2019	**Origination Date:**	11/04/2019

LINE OF BUSINESS

This document applies to the following line(s) of business:
All Lines of Business

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the BSWH P&P Definitions document.

None.

POLICY

Scott and White Health Plan, and its wholly owned subsidiaries (together "Plan") are committed to preventing, detecting, and correcting instances of fraud, waste and abuse (FWA) through a systematic, integrated fraud control program. This policy and procedure supports implementation of the Fraud, Waste and Abuse Plans and applicable regulatory requirements for all lines of business.

PROCEDURE

The Special Investigations Unit (SIU) conducts an annual review of prior referrals, regulatory workplans, and current fraud schemes to create an annual auditing and monitoring workplan. SIU also receives direction from the FWA Workgroup regarding investigations to target potential FWA. The FWA Committee supports the SIU and FWA Workgroup by providing oversight, and guidance related to implementation of the Fraud Waste and Abuse Plan.

Detection

The SIU utilizes key elements to detect potential fraud, waste, or abuse and identify potential areas for investigation including, but are not limited to:

- Referrals received from the Compliance Helpline and any other source;
- Review of available industry databases;
- Monitoring regulatory publications to identify trends and schemes;
- Collaboration with Plan workgroups charged with evaluating cost and efficiency of medical and pharmacy claims management.

Upon receipt of a report, or identification of suspected fraud, waste, or abuse, the potential issue is logged and tracked in the case database.

The SIU staff also utilize data analytics software. Medical and pharmacy claims are imported into the analytics software to:

- Conduct claim-level analysis to identify potential improper billing;
- Conduct statistical pattern analysis to identify trends and outliers;

When FWA activities are delegated to another entity, oversight is conducted. The SIU reviews the delegate's analytics and collaborate with the delegate on further investigation as applicable to the situation.

Investigation

Documentation related to the investigation steps below is maintained in the applicable SIU audit workbook or investigation tracking log.

Key elements of the preliminary investigation include, but are not limited to, the following:

- Verification of provider contract status, to include valid licensure and exclusion status;
- Verification of member enrollment status and applicable plan benefits based on line of business;
- Review of previous referral history or complaints related to the provider and/or member;
- Evaluation of potential geographic patterns;
- Evaluation and definition of risk area based on allegation.

The following elements may be evaluated:

- Clinical guidelines and authorizations;
- Coding guidelines;
- Coverage requirements;
- Plan medical policies;
- Medical specialty board best practice guidelines;
- Based on the issue, member telephonic or written survey may be initiated as part of the investigation.

Once the issue is defined based on the above criteria, a claims universe is pulled utilizing the analytics software. Timeframes for review are outlined in Attachment 1.

A preliminary case summary is prepared by the SIU identifying in the claim analytic, to include potential outliers, aberrancies, and assigned provider score as generated by the analytic software. Root cause analysis is performed to evaluate potential policy, process or system revisions to mitigate future risk.

Following presentation to and discussion with the FWA Workgroup, the targets for further review are identified. Random sampling is utilized to generate a claim sample. The sample size is compliant with guidelines in Attachment 1.

Requests for medical records are mailed certified, return receipt. Requested records are required to be complete and submitted within forty-five (45) calendar days of receipt of the letter.

If a provider fails to respond to the record request, the provider is notified by certified return receipt letter as to the following actions:

- Recovery of claims identified in the record request;
- Referral, as required, to the applicable regulatory entity.

Once records are received, the date of receipt is documented. Provider may be contacted to obtain missing information or records.

Record reviews are completed within timeframes noted in Attachment 1. Utilizing the cited guidelines and criteria noted above, evaluation of each record is documented in the designated audit workbook.

Following the record review, a final case summary is issued, reviewing facts of the case to include outcomes of the medical record review and other relevant findings. These findings and recommendations for case closure are shared with the FWA Workgroup for their review and input. The provider is notified of the outcome via certified

return receipt. A copy of this letter is sent to the Provider Relations team for review and provider outreach as applicable.
When the provider meets the criteria for appeal, SIU reviews additional documentation, if submitted. It is preferable that a different investigator, not involved in the initial investigation, review the appeal documentation. Findings of the appeal review are presented to the FWA Workgroup, and a summary letter is sent certified return receipt to the provider. This closes the SIU investigation. Required referrals to regulatory agencies takes place as warranted.

At case closure, relevant documentation is saved in the case file.

ATTACHMENTS

SIU Flow Chart (SWHP.CMP.086.A1)

RELATED DOCUMENTS

Special Investigative Unit Plan to Prevent Medicaid Fraud, Waste, and Abuse – RightCare
Scott and White Health Plan Fraud, Waste, and Abuse Plan
Fraud, Waste, and Abuse Provider Appeals (SWHP.CMP.087.P)

REFERENCES

1 Texas Administrative Code Part 15, Chapter 353, Subchapter F
Uniform Managed Care Contract – Health and Human Services
42 CFR 438.608
Medicare Managed Care Manuals – Chapter 21 and Chapter 9

Attachment Name:	SIU Flow Chart		
Attachment Number:	SWHP.CMP.086.A1	**Last Review/Revision Date:**	11/04/2019

SIU Flow Chart