Fraud, Abuse and Waste Prevention Protocol

**Overview:** South Florida Behavioral Health Network, Inc. (SFBHN) is committed to maintaining high ethical standards in the conduct of its business. The key to upholding those standards is through the daily decisions and actions of every SFBHN employee. We also require highly ethical conduct from our business relationships. Strong commitment to compliance is the foundation of our mutually beneficial business relationships.

The purpose of this document is to describe SFBHN’s strong and explicit organizational commitment to conducting business ethically, with integrity and in compliance with applicable laws, regulations and requirements. SFBHN requires of its 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 policy.

This document includes our goals and requirements relating to the prevention, detection and correction of criminal misconduct, fraud, abuse and waste, including the requirements of our contract with the Florida Department of Children and Families.

**Purpose:** South Florida Behavioral Health Network, Inc.’s Fraud, Abuse and Waste Plan details the prevention, detection, investigation, recovery, and reporting of all suspected cases of waste, abuse or fraud, both internally and externally. This Plan is designed as an element of SFBHN’s Corporate Compliance and Ethics Program. SFBHN and its Network service providers have a fiduciary responsibility to resist criminal behavior, instances of false claims, improper billing or coding practices, and other schemes that adversely impact consumer safety, quality of care and impose a financial burden on the behavioral health care system.

South Florida Behavioral Health Network, Inc. takes fraud, abuse and waste seriously. We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations. SFBHN has made a commitment to actively pursue all suspected cases of fraud, abuse and waste and will work with the Florida Department of Children & Families and law enforcement for appropriate remedies/sanctions.

SFBHN promotes practices that are compliant with all federal and state laws on fraud, abuse and waste. Our expectation is that 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.

SFBHN does not tolerate fraud, waste or abuse, either by network service providers or staff. Accordingly, we have instituted extensive fraud, abuse and waste programs to combat these problems. SFBHN’s programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, abuse and waste.
Our policies in this area reflect that both SFBHN and network service providers are subject to federal and state laws designed to prevent fraud and abuse in government programs and federally funded contracts. SFBHN 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.

**Anti-Fraud Goals**

SFBHN'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 - An effective anti-fraud program demonstrates the company's strong commitment to honest and responsible provider and corporate conduct.

3. Assessment of Risk - The program will facilitate a more accurate view of risk and exposure relating to fraud and abuse.

4. Public, Legislative and Contract Compliance - The program facilitates compliance with state/federal laws and effective contracts, and demonstrates an aggressive approach to fighting fraud/abuse.

5. Civic Responsibility - Combating fraud/abuse through identifying and preventing criminal and unethical conduct is considered a public duty.

6. Financial Savings - Through prevention, early detection and recovery, minimizing the loss to the State of Florida and its taxpayers from false claims is a priority.

7. Deterrence - Future deterrence of fraud/abuse is a priority.

8. Objective Invoice Review - Standard, unbiased invoice review is required by law and is smart business.

**Defining Fraud, Abuse and Waste**

_Fraud:_ means 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. It includes any act that constitutes fraud under applicable federal or state law.

_Abuse:_ means 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.
**Waste:** means over-utilization of services or other practices that result in unnecessary costs.

Some examples of fraud, abuse and waste 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. Misrepresenting the services performed (e.g., up-coding to increase reimbursement);
4. 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);
5. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act;
6. Routinely waiving consumer co-payments;
7. Providing or ordering medically unnecessary services and tests based on financial gain;
8. 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);
9. 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., a therapist billing two individual psychotherapy sessions on the same day for the same patient);
10. Providing services over the telephone or Internet and billing using face-to-face codes;
11. Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of consumers allowed per group session);
12. Treating all consumers weekly regardless of necessity;
13. Routinely maxing out of consumers benefits or authorizations regardless of whether or not the services are necessary;
14. Inserting a diagnosis code not obtained from a physician or other authorized individual;
15. 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);

16. Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs; and

17. Lying about credentials, such as degree and licensure information.

18. Misuse of consumer funds through network service providers.

19. Charging consumer co-payments not consistent with sliding fee scales.

20. Network service providers not billing Medicaid for Medicaid eligible consumers.

21. Theft - taking the property of another without right or permission.

22. Failure to report known or suspected neglect or abuse of client.

SFBHN's responsibility is to implement and regularly conduct fraud, abuse and waste prevention activities that include:

1. Extensively monitoring and auditing provider utilization and billing to detect fraud, abuse and waste;

2. Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct;

3. Reporting suspected fraud, abuse and waste 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 (TANF);

6. Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned;

7. Training employees annually on SFBHN's Corporate Compliance and Ethics Handbook;

8. Training providers on SFBHN's Corporate Compliance and Ethics Handbook;

Anti-Fraud Plan

The components of the SFBHN Anti-Fraud Plan are as follows:

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

I. PREVENTION, DETECTION, INVESTIGATION OF FRAUD

A. External Fraud

1. Prevention and Detection

SFBHN strives to detect and prevent health care fraud, abuse and waste through several avenues to include, but not limited to; complaints/grievances, incident reports or incident trends, data reports, monitorings and through the use of sophisticated fraud detection based methodologies.

SFBHN seeks to detect fraud, abuse and waste through a variety of methods as follows:

Fraud Detection Technology

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

SFBHN will utilize data mining capabilities and other technological tools in preventing and detecting fraud, abuse and waste, 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 SAMH services. Based on the analysis, providers that stand out 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.
Provider Fraud, Abuse and Waste

Detection of Provider Fraud, Abuse and Waste: SFBHN uses the following mechanisms available to detect potential fraud, abuse and waste:

1) Trending of provider complaints, billing and utilization patterns;
2) Ad Hoc reporting, custom analyses, specialty profiling and outlier detection;
3) SFBHN’s data system automatically flags common service data errors for validation such as: Funding Source, Overlapping Services, Residential Level 2 service + Other Service, Missing or Invalid Service Start time, Start time before 7 am, Units of Service (Procedure vs. Cost Center), Unknown procedure code, Site code, Invalid combination of cost center, program or funding combination, Invalid Contract number, Last Residential Day, Procedure vs. program, Contains KIS system Error, consumer ineligible to receive service and provider not eligible to provide service. During the processing and review of invoices, SFBHN reviews dates of service to determine if any billing has been submitted for services that did not get automatically flagged for validation.
4) Review of HHS Office of Inspector General (OIG) exclusions and state license actions and updates for identified, excluded/unlicensed providers. SFBHN terminates provider contracts for excluded providers;
5) A Consumer/Provider Hotline (1-888-248-3111) will be used to report fraud, abuse and waste. The Hotline will be communicated to the providers and consumers through the use of the provider and consumer manual, orientations and provider newsletters;
6) Payment review methodologies will be utilized to detect suspicious cases to include: up-coding, bundling/unbundling, and utilization patterns;
7) Invoice validation to compare YTD invoiced services to YTD data.
8) Reporting to the CQI Division from staff, consumers or providers and State and Federal agencies.

Fraud /Suspicious Billing Notification Sources

The identification and prevention of fraud, abuse and waste is a cooperative effort, involving all employees. All employees are required to cooperate in any investigation conducted by SFBHN, DCF, or law enforcement.

SFBHN receives fraud, abuse and waste and/or suspicious claim notification from the following sources:

1) Hotline
2) Tips from consumers, providers and the general public received by SFBHN;
3) Incident reporting;
4) Complaints from provider staff;

5) Media reports;

6) Information obtained in conjunction with monitorings conducted by SFBHN;

7) Office of Inspector General's (OIG) database of excluded individuals/entities;

8) Referrals from the Florida Department of Children and Families, or other agencies engaged in identifying, investigating and prosecuting fraudulent activities.

2. Investigation

1) SFBHN Investigation Procedures include, but are not limited to, the following topics:
   a. Information for investigators regarding general investigation guidelines; conducting interviews; report writing; information disclosure; law enforcement relations;
   b. The process to be employed when a suspicious claim is identified;
   c. The suspicious billing indicators;
   d. The duties and functions of the Investigators.

2) Through the course of its investigations, SFBHN investigators may work with any other division within SFBHN, or other regulatory bodies (i.e. DCF SAMH Program office, AHCA, etc.) to review questionable billing and provide guidance.

3) The quality and credibility of allegations or suspicious situations are assessed. Initial exposures and recovery potential are identified to determine if a case should be opened.

4) Cases are prioritized pursuant to commonly accepted business practices and business objectives, as well as potential jeopardy to consumers.

5) An investigative action plan/timeline is developed to guide the investigation. The action plan is periodically reviewed and revised as circumstances change.

6) Relevant billing data for the period in question is obtained and reviewed and evidence is gathered to support data analysis and allegations.

7) 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.

8) An investigative summary/report is prepared, within 30 days of initial complaint or information received, which summarizes the investigative findings, displays a comprehensive understanding of the facts and financial implications and recommends a corrective action plan to include reporting as appropriate and follow-up.
SFBHN will conduct a preliminary investigation of a potential fraud, waste, or abuse case. This investigation methodology may include:

1) Previous investigations or reports of fraud, waste, and abuse by the 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;

2) Provider complaint logs;

3) Reports of provider paid billing, denied billing, and encounter data for a minimum of the contract term (as available);

4) Internal policies and procedures, SFBHN and state defined policies and procedures and state and federal regulations;

5) Communication with consumers and providers during the course of the investigation to confirm treatment was received or provided;

6) Annual Contract Monitoring Risk Assessment;

7) Secret Shopper calls.

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

1) Automatic Corrective Action Plan;

2) Recoupment of funds tied to the date span audited (e.g. 24 month period).

3) Report findings to credentialing, licensing, and public bodies.

4) Review participation in SFBHN network and for possible contract termination.

5) Report findings to SFBHN Attorney for review of legal issues, and when necessary, the SFBHN Board of Directors.

6) Human Resources to manage disciplinary process when internal SFBHN staff is involved.

7) All providers that do not comply with an SFBHN audit will be reported to the Florida Department of Children and Families – OIG.

B. Internal Fraud; Prevention, Detection and Investigation

SFBHN has adopted fraud prevention, detection and investigation procedures. Following is a summary of SFBHN's fraud, abuse and waste control procedures that serve to prevent internal fraud, abuse and waste.
Comprehensive Internal Compliance Program

The current SFBHN Corporate Compliance and Ethics Program provides, among other things, for the reporting of compliance issues. Employees report improper activity to their supervisors, the Chief Compliance Officer (CCO), or anonymously to the Compliance Hotline. The Corporate Compliance and Ethics Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of compliance issues. The Compliance Program provides that compliance concerns will be investigated rigorously and resolved promptly. Investigations regarding compliance program violations are conducted by the Chief Compliance Officer and/or Human Resources, depending upon the nature of the violation. Compliance and fraud and abuse training is provided to all new employees and to existing employees on an annual basis.

1. Employees who violate the Corporate Compliance and Ethics Handbook are subject to sanctions, including, but not limited to, termination of employment. Employee orientation training and processes include statements about disciplinary guidelines and the importance of enforcement standards.

2. Disciplinary guidelines known as Corrective Action Guidelines are reviewed with all employees during initial orientation. These guidelines are designed to encourage fair and impartial treatment of all employees. This policy is administered without discrimination and in full compliance with our Equal Employment Opportunity philosophy.

3. SFBHN employees are strictly prohibited from engaging in any activity that violates applicable state and/or federal law, the Corporate Compliance and Ethics Handbook, the standards of conduct, or the applicable policies and procedures. Violations may be grounds for termination or other disciplinary action, depending on the circumstances of each violation as determined by the Human Resources Department in consultation with the Corporate Compliance Officer or designee.

4. Disciplinary action is taken against employees who authorize or participate directly in a violation of applicable state or federal law, the Corporate Compliance and Ethics Handbook, standards of conduct, or policies and procedures, and any employee who may have deliberately failed to report such a violation or who hinders an investigation. SFBHN disciplines any employee who has deliberately withheld relevant and material information concerning a violation of applicable state and/or federal law, the Compliance Handbook, the standards of conduct, or the applicable policies and procedures and takes appropriate actions to prevent reoccurrence.

5. In cases in which disciplinary action may be appropriate, the CCO (or delegate) will work with Human Resources and the relevant supervisor to implement such actions. If agreement cannot be reached on a disciplinary action, the matter will be discussed with senior executive management, as applicable. If agreement cannot be reached at the executive manager level, the matter may be referred to the SFBHN Board of Directors for resolution.
II. RECOVERY

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

To this end, SFBHN’s CQI Division, Contract Accountability Unit and IT utilizes all available methods to detect improper billing and coding practices and employs competent investigators, data analysts and other professionals to detect, remedy and recoups identified overpayments. These recovery efforts are integral to the anti-fraud, abuse and waste efforts of SFBHN and supplement the other responses to such behaviors and the procedures outlined in the SFBHN Compliance Program.

1. If the investigation supports fraudulent and/or suspicious billing patterns corrective actions are required and may include;
   1) Identification of inappropriate payments
   2) Notification to a provider of Monitoring Plan
   3) Requirement of Corrective Action Plan (CAP)
   4) Recommendation for Provider Education
   5) Updates to key management staff
   6) Notifying DCF and the OIG, per CFOP 180-4, Mandatory Reporting Requirements to the Office of Inspector General.
   7) Documentation of findings at the conclusion of the investigation
   8) Confirmation that corrective actions are completed
   9) Contract suspension or termination

2. 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.

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

Corrective Action Plan

1. The CQI and Fiscal Divisions coordinate with providers to develop and implement one or more of the following as part of the Corrective Action Plans:
   1) Payment plan to recover overpayments.
2) Provider submission of a detailed Corrective Action Plan (CAP).

3) CQI maintained Monitoring Program. The monitoring program may be for a six (6) month or twelve (12) month time period, as determined by the Chief Compliance Officer, and involves additional audits to ensure adherence to the submitted CAP.

4) Provider education or technical assistance as required.

III. REPORTING

Pursuant to DCF regulations, information regarding suspected fraud, abuse and waste shall be reported to the Florida Department of Children and Families and when meeting criteria, reported to the OIG, within 2 business days of discovery (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.

SFBHN shall cooperate fully with the Florida Department of Children and Families, and/or other law enforcement agencies in their prosecution or additional investigation of cases reported on behalf of SFBHN.

A log of all incidences of suspected fraud, abuse and waste received by SFBHN, regardless of the source, will be maintained in the CQI Division. All information to support fraud, abuse and waste 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/Fraud, Abuse and Waste Awareness Training
Pursuant to SFBHN policy, anti-fraud education and training of staff and network service providers is mandatory.

SFBHN has initiated a Fraud Awareness Campaign. The purpose of this program is to encourage and assist SFBHN's employees, providers, consumers and other customers to identify, detect, and report health care fraud, abuse and waste.

The SFBHN Chief Compliance Officer is in process of becoming certified in Health Care Compliance and SFBHN is a member of the Health Care Compliance Association (HCCA).

The corporate compliance and ethics training program is broad in scope. The intent is to address fraud, abuse and waste and the impact that it can have on SFBHN. Its objectives are to provide staff members with specific tools to detect fraud, abuse and waste, instruct them in the procedures for reporting cases of suspected fraud, abuse and waste, and create an awareness of the staggering financial and service consequences of fraud, abuse and waste.

All personnel are required to attend Fraud Awareness & Compliance Training every year. All new SFBHN staff members are provided Fraud Awareness Training as part of the orientation process. Non-compliance with SFBHN's Compliance and/or Fraud Awareness Training will result in disciplinary action. Employees should receive specialized training on issues posing compliance risks based on their job function upon initial hire and at least annually thereafter as a condition of employment.

The focus will be on the critical role that each employee plays in the eradication of fraud, abuse and waste committed against SFBHN and its stakeholders. Highlights of the program include:

1. Definition of fraud, abuse and waste;
2. Tools for fraud, abuse and waste detection ("red flags");
3. SFBHN's prevention efforts;
4. Reporting fraud, abuse and waste;
5. Review of actual investigations;
6. Current industry trends in the fraud, abuse and waste arena;
7. Investigative Procedures;
8. Unique Department Procedures.

B. Investigator Education/Training
Upon hire, SFBHN investigators complete a comprehensive fraud detection-training course that provides the new investigator with information about SFBHN's Anti-Fraud Plan as well as material regarding techniques used to combat fraud, abuse and waste.

SFBHN staff members receive technical fraud, abuse and waste training through attendance at various seminars and workshops. SFBHN staff members participate in the trainings that relate most directly to their specialty or position.

Additional training sessions will include technical/computer training that will occur throughout the year and address various computer applications used.

C. Provider Education/Training

The provider network will be educated about the Fraud, Abuse and Waste Plan through a variety of mechanisms. Upon contracting with SFBHN, Contract Management will schedule an orientation with the provider to go over the contract requirements, including the Fraud, Abuse and Waste Plan. Documentation of this is recorded in the Contract Manager’s file.

The Fraud, Abuse and Waste Plan is available to the provider network through the SFBHN website. SFBHN requires all subcontracted providers to submit their fraud, abuse and waste plan annually and affirm the responsibility of the provider to report all cases of suspected waste, abuse and fraud. All subcontractors and agents are required to provide fraud, abuse and waste training to their staff.

V. PRIMARY CONTACT PERSONS/ORGANIZATIONAL CHART

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 SFBHN Anti-Fraud Plan should be directed to:

Laura Naredo, MS
Chief Compliance Officer
Vice President, Continuous Quality Improvement and IT
South Florida Behavioral Health Network, Inc.
7205 Corporate Center Drive, Suite 200
Miami, FL 33126
(786) 854-5836 – direct line for office
(786) 247-2851 - cell
lnaredo@sfbhn.org

Responding to DCF Inquiries

SFBHN Vice President for Continuous Quality Improvement and IT will be the primary contact for all related inquiries and ensures that SFBHN cooperates fully with any Florida Department of Children and Families investigation.
Whistleblower Protection and Non-Retaliation policy

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

3. SFBHN does not retaliate against any of its subcontractors 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 SFBHN from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a False Claims Act action.