Name:	**Fraud, Waste, and Abuse Detection and Prevention**
Date of Origin:	**10/23/2002**
Current Effective Date:	**08/21/2024**
Scheduled Review Date:	**08/21/2025**

I. Policy Overview

Capitol Dental Care (CDC) and its employees and subcontractors will comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste, and abuse ("FWA") in the provision of health care services to our members and payment for such services to dental health care practitioners. This policy establishes the plan for fraud, waste, and abuse prevention, detection, and reporting. It applies to all CDC employees and subcontractors. In addition, CDC provides new hires FWA training within 60 days of hire. The FWA training is also provided to existing employees on an annual basis, including those responsible for credentialing. CDC also distributes to its employees and subcontractors written standards of conduct that promote CDC's commitment to compliance, and those standards address additional areas of potential fraud.

CDC has internal controls and procedures designed to prevent and detect potential fraud, waste, and abuse activities by members, providers, and employees. This plan includes policies and controls in areas such as claims, prior authorization, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and CDC employee education, and corrective action plans to address fraud, waste and abuse activities. Cases of potential FWA as indicated in the Oregon Administrative Rules will be reported to the appropriate regulatory agency. This policy will be reviewed and revised, as necessary, but no less than on an annual basis.

CDC has staff dedicated to implementing the Annual FWA Prevention Plan. CDC has an appointed full time Chief Compliance Officer charged to develop, implement, and oversee compliance effectiveness, the Compliance Plan, and the FWA Program. A Compliance Support employee assists in this effort and reports to the Chief Compliance Officer. The Chief Compliance Officer reports to the CDC President (Chief Executive Officer). CDC's Compliance Committee has been developed with a charter of responsibilities. Members of CDC's senior leadership, including the Chief Compliance Officer, are members of the Compliance Committee.

The members include, but are not limited to:

- Dr. Manu Chaudhry, President
- Kristin Soto, General Manager
- Victor Kintz, Compliance Officer
- Sarah Bell, Compliance and Data Analytics Support
- Hart Laws, President Emeritus
- Kristin Hockema, EPDH, BS, Community Outreach

II. Definitions

Abuse – An activity or practice undertaken by a member, practitioner, employee, or contractor that is inconsistent with sound fiscal, business or dental practices and results in unnecessary cost to reimburse for services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge (or with reckless disregard) that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR 455.2). Member fraud may include a member's misuse of a dental card, altering or forging a prescription, theft, or any fraudulent activity committed against CDC or any subcontractor.

Incident - A situation of possible fraud, abuse, neglect, and/or exploitation which has the potential for liability to the State of Oregon, community CCO partners, CDC or subcontractors.

Potential – If, in one's professional judgment, it appears as if an incident of fraud or abuse may have occurred. The standard of professional judgment used would be "**that judgment exercised by a reasonable and prudent person acting in a similar capacity.**"

Waste - The extravagant, careless, or unnecessary utilization of or payment for health care services.

III. Federal Laws

As a contractor participating in federal health care programs, CDC is required to comply with the following federal laws:

False Claims Act - The federal civil False Claims Act (FCA") is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government's ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid.

Under the statute the terms "knowing" and "knowingly" mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, treating members that pay cash for services different from members that participate in a health plan, unbundling of services (where the law requires the service remain bundled), and up-coding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation, or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than ten years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than $5,500 and not more than $11,000, plus up to three times the amount of damages sustained by the federal government. The United States Department of Justice may also bring criminal charges under FCA in appropriate circumstances. The criminal provisions of the FCA provide for significant fines and up to 5 years in jail.

Qui Tam and Whistleblower Protection Provisions - The False Claims Act contains a *qui tam*, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government.

A *qui tam* action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has sixty days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim. However, if the government decides not to join, the whistleblower may pursue the action alone, but the government may still join at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent) plus attorneys' fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed, or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest, and compensation for any special damages including attorneys' fees and costs of litigation. Please see CDC's policy on Zero Tolerance for Retaliation in response to reporting misconduct.

Federal Program Fraud Civil Remedies Act Information - The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents, or submits, or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious, or fraudulent is subject to civil money penalties of up to $5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

IV. State Laws

False Claims – Oregon law prohibits a person from (1) presenting, or causing to present, for payment or approval a claim to a public agency that the person knows is a false claim; (2) making or using, in the course of presenting, or causing to present, a claim to a public agency for

payment or approval, a record or statement that the person knows is a false claim; (3) agreeing or conspiring with other persons to present for payment or approval a claim to a public agency that the person knows is false; (4) making or using, or causing to be made or used, a false or fraudulent statement to conceal, avoid, or decrease an obligation to pay a public agency if the person knows that the statement is false or fraudulent; or (5) failing to disclose a false claim to a public agency that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval. The Oregon Attorney General may bring a civil action against a person that violates this law. If a violation is proven, a court can order the person who violated the law to repay the government for all damages and order a penalty equal to the greater of $10,000 for each violation or an amount equal to twice the amount of damages occurred for each violation.

Public Assistance: Submitting Wrongful Claim or Payment - Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment which has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment which is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C Felony.

Any person who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) The amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Any person who after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

False Claims for Health Care Payments - A person commits the crime of making a false claim for health care payment when the person: (1) knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or (2) knowingly conceals from or fails to disclose to a health care payer the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled. The district attorney or the Attorney General may commence a prosecution under this law and the

Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Whistle blowing and Non-retaliation - CDC may not terminate, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported fraud, waste or abuse by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste, or abuse, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

Racketeering – An individual who commits, attempts to commit, or solicits, coerces, or intimidates another to make a false claim for health care payment may also be guilty of unlawful racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

V. Fraud, Waste, and Abuse Plan Components

CDC's plan to detect and prevent fraud, waste and abuse is comprised of the following components:

Internal Activities and Controls

CDC maintains the following activities and controls within various departments to promote effective utilization of dental resources and/or identify potential fraud, waste, or abuse occurrences (not inclusive):

- Information system edits and audits claims submitted.
- Post payment review of claims and other claims analysis activities.
- Provider credentialing and re-credentialing policies and procedures, including on-site reviews if applicable.
- Provider and utilization profiling.
- Prior authorization policies and procedures (member eligibility verification, review of dental necessity and appropriateness of service requested, and covered service verification).
- Utilization management and prior authorization policies and procedures, including quality improvement committee and peer review, corrective action planning, and provider participation limitations and or termination as applicable.
- Quality improvement practices, as indicated in CDC's Quality Improvement and Monitoring Plan.
- Dental claims review for appropriateness of services and level(s) of care, reasonable charges, and potential under and over utilization.
- As applicable, follow-up and receive recommendations and referrals from committees such as Quality Improvement, and Credentialing related to providers and utilization.
- Provider education regarding potential fraud, waste and abuse occurrences and reporting

- Employee education regarding potential fraud, waste and abuse occurrences, detection and reporting
- Provider notice by letter and or phone, and training either by phone or face-to-face by CDC Member Services staff, if problem identified.
- Monitoring of provider and member complaints and grievances.
- Ask a member as applicable if he/she received the service and level of billed.
- As applicable, apply risk evaluation technologies to monitor compliance and assist in the reduction of identified problem areas.
- Verification of Services – CDC, through its vendor: Performance Health Technology (PH Tech) sends a **Verification of Services** letter to members who have received services. The mailings occur monthly and are based on a random sampling of 5% of unique members who have paid dates in the previous month. The letter communicates the following:
  1) The communication is NOT A BILL for services
  2) Recipient name
  3) Member ID#
  4) Specific services received, showing provider name, service provided, and date(s) of service, paid amount (if any), amount of payment made by DMAP member (if any).
  5) A request that the member contacts PH Tech customer service if any of the services listed do not agree with the member's account / record / recall of those services.

  The **Verification of Services** letter will not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.

  If PH Tech receives a call from a member related to the **Verification of Service** mailing, PH Tech will notify the plan for investigation in accordance with this policy. Once investigated, CDC will follow up with the Member and/or Provider regarding the findings. If FWA is suspected, OPI and MFCU will be contacted as required.

  CDC will provide to DHS, upon request, verification that DMAP members were contacted to confirm that billed services were provided in accordance with 42 CFR 455.20 and 433.116 (e) and (f).

Reporting Mechanisms and Primary Contact

The CDC Chief Fraud and Abuse Team oversees the investigation of potential fraud, waste and abuse occurrences, and is comprised of the Dental Director, President, and Chief Compliance Officer. (This team is consistent with CDC's senior management Staff).

Employees who interact with providers and members are trained in fraud, waste and abuse detection and reporting. Any potential fraud, waste and abuse occurrence identified by a CDC employee during the course of his/her performance of duties is reported to one of the senior

management staff members. That data is maintained in a log, and any investigation that is performed in response to this information is logged in an Investigations Log.

Additionally, CDC provides our CCO partners with several reporting deliverables, as stipulated in the Contracts. These include, but may not be limited to, the following:

- Quarterly and annual reports of all audits performed. The Annual FWA Audit Report must include information on any Provider Overpayments that were recovered, the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by Contractor on its Subcontractors or Providers.
- An annual summary report of Referrals and cases investigated
- All suspected cases of FWA, including suspected Fraud committed by its employees, Providers, Subcontractors, Members, or any other third parties are reported to OHA's Office of Program Integrity (OPI) Audit Unit and DOJ's Medicaid Fraud Control Unit (MFCU) within seven days.
- Regardless of CDC's own suspicions or lack thereof, to the MFCU, a report of an incident with any of the characteristics listed in Section 16 of the Contract, Exhibit. B, Part 9
- Quarterly and annual Financial Reports required under section 1, paragraph a., subparagraph (2) of Exhibit L, all Overpayments, identified or recovered regardless of whether the Overpayments were the result of (i) self-reporting under subparagraphs (15) and (16) above of paragraph b. section 11, Exhibit B Part 9, or (ii) the result of a routine or planned audit or other review.

Timeliness standards for these deliverables and other notices are outlined in the Contract.

<u>Applicability of the Plan to Contractors and Subcontractors</u>

CDC and subcontractors are required to comply with these policies and procedures. CDC will promote Contractor and Subcontractors compliance with these policies and procedures which:

(a) Promote the Contractor's commitment to compliance;

(b) Address specific areas of potential fraud, such as claims submission process, and financial relationships with its Subcontractors;

(c) Provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b.

(d) Provide as part of the written policies, detailed provisions regarding the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse; and

(e) Include in any employee handbook for the Contractor, a specific discussion of the laws described in subsection (c) of this section, the rights of employees to be protected as

whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

VI. Reporting Suspected Fraud, Waste or Abuse

Each CDC employee has an obligation to report suspected fraud, waste, or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, provider, or member. When an employee suspects fraud, waste or abuse, such employee should complete a Fraud & Abuse Incident Referral Form (use only if the alleged activity involves a member or a provider). Any potential fraud, waste and abuse occurrence identified by a CDC employee during the course of performing CDC duties is initially reported to the department supervisor. The department supervisor or the employee, with the supervisor's guidance, completes a Member Fraud & Abuse Incident Referral Form (Attachment A) or a Provider Fraud & Abuse Incident Referral Form (Attachment B) and sends the respective form to the Chief Compliance Officer for review.

VII. Fraud, Waste and Abuse Investigations

When acting within the scope of this policy, designated CDC personnel have the right to access applicable records necessary to audit or conduct an investigation into allegations of fraud, waste, or abuse. This right to audit or inspect may extend to information subject to attorney-client privilege.

The following summary provides a general overview of the steps typically taken when CDC receives a report of suspected fraud, waste or abuse, though additional steps may be necessary depending upon the circumstances of each case. CDC promptly responds to all detected fraud, waste and abuse offenses.

Members - Upon receipt of an internal member Fraud & Abuse Incident Referral Form (See Attachment A) or other communication, the CDC Fraud and Abuse Team:

(a) Reviews member demographic database information (county of residence, eligibility segments).

(b) Reviews member claims history for a period not less than 12 months previous to month of receipt of referral.

(c) Obtains necessary information based upon the appropriate category of the referral. This may include claims history, dental records, customer service, complaint management, professional relations, or management as circumstances warrant) or obtaining necessary information from outside sources as warranted.

(d) Performs determined necessary audit steps of encounters, billing, medical/dental procedure coding or other information as circumstances warrant to develop data for further analysis and decision.

(e) Review case file information and make referral assessment decision. If the circumstances and data warrant referral, the CDC Fraud and Abuse Team will forward to appropriate state or federal regulatory agencies, or forward OHP plan information to the OMAP Medicaid Fraud Control Unit, the Provider Audit Unit or the appropriate state or federal regulatory agency or CCO community partner. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will be included in the file and the case will be closed.

(f) Provides feedback to originator and management, as appropriate.

Practitioners - Upon receipt of internal practitioner Fraud & Abuse Incident referral Form (See Attachment B) or other communication, the CDC Fraud and Abuse Team:

(a) Reviews provider data base information (county of practice, provider ID#, tax ID#, contract status, provider type/specialty).

(b) Reviews practitioner contract, if applicable.

(c) Reviews practitioner claims history/reconciliation report for a period not less than 12 months previous to month of receipt of referral.

(d) Obtains necessary information based upon the issue/incident raised (such as dental abuse or financial/billing/ encounters, coding abuse). This may include contacting others for relevant information or discussion (dental review, quality improvement, professional relations' practitioner file, customer service, office managers, directors or senior management as circumstances warrant). In addition, the CDC Fraud and Abuse Team may obtain necessary information from outside sources as warranted under the circumstances.

(e) Performs appropriate audit steps of encounters, billing, medical/dental procedure coding or other information as circumstances warrant to develop data for further analysis and decision.

(f) Reviews assembled case file information and make decision regarding the appropriate course of action based upon the facts (e.g., provide billing education to provider's office, put provider on focus review, terminate contract etc.). If circumstances and data warrant referral to an external agency, the CDC Fraud and Abuse Team will forward information to appropriate state or federal regulatory agencies, and will forward OHP plan information to the DHS Audit Unit or other appropriate regulatory agency. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will be included in the file and the case will be closed.

(g) Provides feedback to originator and management, as appropriate.

Employees and Subcontractors – If an employee suspects that another CDC employee or a CDC Subcontractor has engaged in fraud, waste or abuse, the individual should immediately report the

incident to their Supervisor, or Senior Management. The CDC Fraud and Abuse Team is responsible for the investigation and reporting of cases of fraud, waste and abuse committed by CDC employees and subcontractors. Appropriate disciplinary action, up to and including immediate termination of employment, is taken against employees who have violated CDC Fraud, Waste and Abuse policies, applicable statutes, regulations, or Federal or State health care program requirements. In accordance with CDC's policies relating to subcontractors, CDC will ensure that appropriate disciplinary action, up to and including immediate termination of the relationship, is enforced against subcontractors who violate CDC's fraud and abuse policies, applicable statutes, regulations or Federal or State dental care program requirements.

Corrective Action– As necessary based on the outcome of a fraud, waste and abuse investigation, CDC will correct any identified system problems.

VIII. Confidentiality of Investigation

Information identified, researched or obtained for or as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants in the investigation of a potential fraud, waste, and abuse occurrence is maintained solely for this specific purpose and no other. CDC assures the anonymity of complainants to the extent permitted by law. CDC is responsible for maintaining the confidentiality of all potential fraud, waste, and abuse information identified, researched or obtained, in accordance with the terms and conditions of CDC' Confidentiality Policy.

IX. Coordination with External Agencies

The CDC Fraud and Abuse Team coordinates all information requests and reporting, whether initiated internally or externally. CDC promptly refers all suspected cases of fraud, waste and abuse by groups, members, practitioner and employees of the organization to the appropriate regulatory agencies for further investigation. In addition, CDC assists various governmental agencies as practical in providing information and other resources during the course of investigations of potential practitioner or member fraud or abuse. These agencies include, but are not limited city, county, state and federal agencies; the OHA Provider Audit Unit, the Medicaid Fraud Control Unit of the Oregon Attorney Generals' Office, CCO community partners, as applicable and the United States Office of the Inspector General.

X. Suspended, Debarred and Excluded Practitioners

Participating practitioner contracts stipulate practitioner responsibilities to comply with all applicable Federal, State and local laws, rules and regulations, to maintain and furnish records and documents as required by law. Practitioners who are found to have violated a state or federal law regarding fraud, waste and abuse or are suspended, debarred or excluded from participation in federal programs will have the practitioner's participating provider agreement with CDC.

Except in very limited circumstances (i.e., provision of emergency services, sole source provider), the following individuals or entities may not be reimbursed from federal funds for otherwise covered services provided to CDC members:

1. Practitioners who are currently suspended, debarred or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to any executive order or under guidelines implementing such order;

2. Persons or entities who are currently suspended or terminated from MAP or excluded from participation in the Medicare program; or

3. Persons who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII or XX of the Social Security Act and/or related laws (or entered a plea of nolo contendere).

CDC does not refer members to such suspended or terminated practitioners and does not accept billings for services to CDC members submitted by such practitioners.

XI. Periodic Review of Policies and Procedures

CDC shall review its fraud, waste and abuse policies at least annually and will submit any such revised policies to the Department of Human Services, Division of Medical Assistance Programs, Medical Section, Quality Assurance and Improvement Unit on or before March 15th of the current contracted calendar year. CDC will also review and revise these policies and procedures to address problems in any risk evaluation techniques or internal controls.

XII. Revision Activity

Modification Date	Change or Revision and Rationale	**Effective** Date of Policy Change
12/15/2007	Annual Update	01/01/2008
02/17/2010	Annual Update	05/01/2010
05/01/2011	Annual Review	05/01/2011
09/30/2011	Update	9/30/2011
02/06/2012	Update	02/06/2012
6/26/2013	Annual Review Scheduled	6/26/2013
11/13/2014	Annual Update	11/13/2014
11/12/2015	Annual Update	10/28/2015
10/26/2016	Annual Update	10/26/2016
1/18/2018	Annual Update	1/18/2018
2/18/2019	Review	2/18/2019
2/18/2020	Review	2/18/2020
2/10/2021	Review and Update	2/10/2022
10/11/2021	Revision	10/20/2021
06/22/2022	Revision	06/22/2022
06/28/2023	Revision	06/28/2023
08/16/2023	Reviewed	08/16/2023

8/21/2024	Review Only	8/21/2024

XIII. Affected Departments:

All CDC Employees and Contractors

XIV. References:

Employee Handbook
CDC Deficit Reduction Act False Claims Act Notification
Employee and Contractor False Claims Act Policies and Procedures
Zero Tolerance Policy in response to retaliation for reporting misconduct.
Provider Contracts
False Claims Act
OAR 410-120-1380