**Policy and Procedure**

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|---|---|---|
| **Policy Name:** Fraud, Waste and Abuse (FWA) | **Policy#:** CMP-211 | **Version#:** 25 |
| **Author Department:** Compliance | **Origination Date:** 4/1/2003 | |
| **Business Units Impacted:** All | **Date Last Reviewed:** 9/16/2024 | |
| **Products/LOBs:** All | **Date Approved by CPT:** 10/10/2024 | |

## DEFINITIONS

**Fraud**: 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.

**Waste**: Incurring unnecessary costs as a result of deficient management, practices, systems or controls; the over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

**Abuse**: Practices that are inconsistent with sound fiscal, business or medical practices, and that result in an unnecessary cost to government programs, or in seeking reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary cost to Medicaid programs.

**Neglect:** Neglect is the willful failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including any neglect that constitutes a criminal violation under state law.

**Exploitation:** Exploitation includes any wrongful taking or use of funds or property of a patient residing in a health care facility or board and care facility that constitutes a criminal violation under state law.

**False Representation:** False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a provider or client who has actual knowledge of the truth or false nature of the statement or by a provider or client acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

**Medicaid Member Fraud:** Medicaid member fraud refers to intentional deception or misrepresentation by a Medicaid member to secure benefits or services to which they are not entitled. This includes, but is not limited to, falsification of eligibility information, fraudulent claims, and misuse of Medicaid benefits.

**Overpayment:** Payment that exceeds the amount due or payable for services rendered, often resulting from billing errors or miscalculations. Overpayments may result from errors such as duplicate billing, incorrect coding, or misinterpretation of contracts, and can also occur due to fraudulent activities, wasteful practices, or abusive billing patterns.

**Retaliation:** Any adverse employment action for reporting a compliance issue or concern, including termination, demotion, harassment, or other negative consequences.

**Workforce Members**: Means individuals who are employed by or affiliated with Colorado Access (COA or organization), including full-time and part-time employees, temporary staff, contractors, volunteers, interns, and other personnel who perform work on behalf of the organization.

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**SCOPE:**
This policy applies all Workforce Members. It encompasses all operational areas, including financial transactions, claims processing, procurement, and health care service delivery, where the potential for fraud, waste, or abuse exists. It also extends to third-party entities or individuals involved in the organization's operations.

**PURPOSE:**
The purpose of this policy is to establish a comprehensive framework for preventing, detecting, and addressing fraud, waste, and abuse (FWA) within COA. This policy is designed to protect the organization's resources, ensure compliance with legal, regulatory, and contractual obligations, and uphold the integrity of our operations. By fostering a culture of transparency, accountability, and ethical conduct, we aim to safeguard public trust and ensure the efficient and ethical delivery of healthcare services.

**STATEMENT OF POLICY:**
COA is dedicated to upholding the highest standards of quality and ethics, ensuring all business activities comply with Federal, State, and local laws, as well as applicable regulatory guidelines. COA has established mechanisms to prevent, detect, investigate, and address potential or actual incidents of FWA, in line with contractual, regulatory, and statutory requirements. Any violations of COA policies, the Code of Conduct, or incidents of fraud, waste, or abuse will result in appropriate disciplinary action in accordance with COA's policies and procedures.

**PROCEDURES:**

**A. Prevention**

**1. Education and Training**

Regular compliance training and education on FWA laws, regulations, detection, prevention, and reporting are provided to all Workforce Members in accordance with the CMP-204 Compliance Education and Training Policy.

**2. Policies and Procedures**

COA establishes and maintains clear policies, procedures and guidelines for billing, medical record documentation, and claims submission to minimize the risk of FWA.

**3. Exclusion Screening**

COA maintains a process for the initial and ongoing screening of employees, providers, and other individuals or entities seeking a relationship with COA, to ensure compliance with contractual obligations and legal requirements. This process verifies that no prohibited relationships exist by screening against applicable databases and sources to

identify exclusions from participation in federal health care programs, as outlined in the CMP-206 Sanctions Screening policy.

**B. Detection Mechanisms**

**1. Reporting**

a. COA requires all individuals to report known or suspected violations of law or incidents of FWA in accordance with CMP-201 Compliance Problem Reporting and Non-Retaliation policy. Reports can be made anonymously, and all reports will be treated confidentially to the extent possible. Retaliation against anyone who reports suspected FWA in good faith is strictly prohibited.

Individuals may use any of the following reporting channels:

- **Compliance Hotline**: 877-363-3065 (Available 24/7)
- **Email**: compliance@coaccess.com
- **Online Portal Link**: EthicsPoint - Access Management Services, LLC
- **Direct Reporting**: Concerns may also be reported directly to a supervisor, manager, the Director of Compliance Programs or a member of the Compliance Team.

**2. Audits and Monitoring**

a. COA performs regular analysis of claims data and provider billing practices to identify patterns indicative of FWA (e.g. high billing volumes or frequent high-cost services), suspicious activities, and overpayments. Additionally, COA has a process in place for verifying members utilization of services.

b. The Compliance Team submits a monthly report of overpayments related to FWA to Health Care Policy and Finance (HCPF) as stipulated by contractual obligations. For more detail, refer to CMP-DP15 Monthly FWA CHP & RAE Overpayments desktop procedure.

c. The use of claims data analytics is evaluated during audits to identify patterns or provider outliers that may indicate fraudulent or wasteful activities. For more detail, refer to CMP-D16 Pulling Claims Data – SQL Server desktop procedure.

d. The Compliance Team verifies COA members have received health care services as stipulated by contractual obligations. For details, refer to CMP DP08 Compliance Program Operations Manual desktop procedure.

**C. Investigation**

1. The investigation process begins when a report of potential or actual FWA is received through any source (e.g., internal audits and monitoring, the compliance hotline, Workforce Member report, external audits etc.).

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2. The Compliance Team conducts an initial assessment of the issue to determine if sufficient evidence exists to justify a full investigation. This may involve reviewing pertinent records (e.g., claims, billing records, contracts) and cross-referencing them with internal policies and guidelines.
3. If the report is valid, the Compliance Team will proceed with a full investigation.
4. If deemed invalid, the case will be closed with a documented reason for closure.

**D. Notifying State Agencies and Other Entities**

1. The Director of Compliance Programs or a designee will ensure that all confirmed instances of FWA, including Medicaid Member Fraud, are reported to the relevant regulatory agencies, including the Medicaid Fraud Control Unit (MFCU), as required. This process involves coordinating the submission of all necessary documentation, such as investigative findings, supporting evidence, forms and details of any corrective actions taken. The Director will also make certain that all reports meet the specific requirements and deadlines established by each regulatory authority.

**E. Enforcement and Correction**

1. The Director of Compliance Programs or a designee recommends appropriate corrective actions for violations of the Compliance Plan, Code of Conduct or policies and procedures.
2. The Compliance Team will work with operational areas to implement process improvements to prevent recurrence when needed (e.g., additional training, tightening controls).
3. At the request of, or with the approval of, the relevant State agencies, COA will suspend payments to any participating provider who is subject to a credible allegation of Fraud. Payment suspension will not occur if State agency officials specifically request that such action be withheld to avoid compromising an ongoing investigation. COA will work collaboratively with State agencies to provide additional information or perform follow-up actions as requested.
4. If an incident of Fraud involves a member that has knowingly provided incorrect information to COA, the organization may take action to request the member's immediate disenrollment. The process will include a thorough review of the member's case to ensure that the decision is fair and justified, and all relevant documentation will be provided to support the disenrollment request.

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**F. Confidentiality and Non-Retaliation**

1. **Confidentiality**
   All FWA-related investigations and reports will be handled as confidentially as possible to protect the identities of those involved and to maintain the integrity of the investigation.

2. **Non-Retaliation**
   The organization will not retaliate against individuals who report suspected or actual instances of FWA in good faith. Any form of retaliation will be addressed according to the organization's policies. For more details refer to CMP-201 Compliance Problem Reporting and Non-Retaliation.

**G. Review and Updates**

This policy will be reviewed annually and updated as necessary to ensure compliance with applicable laws and regulation.

**H. Record Retention**

COA will retain all records in accordance with CMP-210 Record Retention and Destruction Policy.

**REFERENCES:**

CMP201 Compliance Problem Reporting and Non-retaliation
CMP204 Compliance Education and Training
CMP206 Sanctions Screening
CMP212 False Claims Act
CMP-DP08 Compliance Program Operations Manual
CMP-DP15 Monthly FWA CHP & RAE Overpayments
CMP-D16 Pulling Claims Data – SQL Server

**ATTACHMENT:**

None

**POLICY HISTORY:**

**SUMMARY OF REVIEW/REVISION/APPROVAL DATES:**

Version 1: April 1, 2003, Version 2: September 1, 2004, Version 3: October 1, 2005, Version 4: November 1, 2006. Version 5: March 1, 2007, Version 6: August 1, 2007, Version 7: May 1, 2008, Version 8: January 1, 2009, Version 9: July 1, 2009, Version 10: August 1, 2010, Version 11: July 1, 2011, Version 12: May 1, 2012, Version 13: May 1, 2013, Version 14: February 1, 2014, Version 15: February 1, 2015, Version 16: March 1, 2016, Version 17: March 1, 2017,

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**APPROVAL BODY:** COA Core Policy Team **APPROVAL DATE:** 10/10/2024