Comprehensive Behavioral Health Management/College Health IPA **Policy and Procedure Manual**	
Policy Name: Claims Fraud	**Claims**
Date: 11-08 **Reviewed by QI Committee**: 11-08, 7-09, 7-10 **Revised by QI Committee**: 7-09	**Page:** 1 of 2 **Policy Number**: CL-3

Purpose: To ensure that Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) adheres to all state and federal regulations concerning claim submission and payment and that CBHM/CHIPA, providers, and members are protected from fraudulent billing practices.

Policy:

1.0 Prevention

- 1.1 IT Access Rights - CBHM/CHIPA establishes access rights for each employee based upon their job function. Reference SC-4, *"Scope of Access"*
  - 1.1.1 Employees who create provider payment authorizations are not able to create provider files or post a provider claim for payment.
  - 1.1.2 Employees who create provider files are not able to post a provider claim for payment.
  - 1.1.3 Employees who post provider claims for payment are not able to create a provider file or a provider authorization for payment.
- 1.2 Tax ID Review – All claims are posted against provider authorizations. The provider authorization references the provider's Tax ID on file. This Tax ID must match the Tax ID submitted on the claim.
- 1.3 Check Review
  - 1.3.1 The Vice-President of Financial Operations and the President/CEO review all checks over $5,000 prior to mailing.
  - 1.3.2 The Vice-President of Financial Operations reviews all non-MD checks over $1,000 prior to mailing.
  - 1.3.3 The Manager of Network Management reviews the check register for any provider name not recognizable.
- 1.4 Audits
  - 1.4.1 The Claims Manager and/or the Claims Team Lead conduct random claims audits weekly.
  - 1.4.2 The Financial Auditor for CBHM/CHIPA conducts random claims audits during the annual audit.

2.0 Identification

- 2.1 Whenever a potential claims fraud is identified it should be reported to either the Vice-President of Financial Operations or the Vice-President of Product Management and Compliance.
- 2.2 Identification can occur as a result of
  - 2.2.1 Prevention activities noted in Section 1.0
  - 2.2.2 Investigation of a patient complaint
  - 2.2.3 Investigation of a provider complaint

2.2.4 Medical record audit
2.2.5 Employee performance evaluation

2.3 When potential claims fraud is identified, the Claims Fraud Investigation Report is completed.

3.0 Investigation

3.1 Upon receipt of a completed Claims Fraud Investigation Report, the Vice-President of Financial Operations and/or the Vice-President of Product Management and Compliance initiate an investigation.

3.2 The investigation may include one or more of the following activities
3.2.1 Phone conversation with member
3.2.2 Phone conversation with provider
3.2.3 Review of provider medical records
3.2.4 Review of submitted claim forms
3.2.5 Review of ledger history

3.3 Investigation activities may be assigned to other Senior Management staff as needed.

3.4 All notes regarding the investigation are entered into the electronic record either as provider notes or member notes, when a complaint is member specific.

4.0 Response

4.1 If the investigation concludes that there was no intentional claims fraud, the actions taken may include one or more of the following:
4.1.1 Member education
4.1.2 Provider education
4.1.3 Claims refund request
4.1.4 Provider placed on probation with corrective action required
4.1.5 Notification to payer

4.2 If the investigation concludes that there was intentional claims fraud, the actions taken will include:
4.2.1 Claims refund request
4.2.2 Termination of CHIPA provider agreement
4.2.3 Notification to payer

5.0 Reporting

5.1 All Claims Fraud Investigations will be reported to the QI Committee. The QI Committee will trend and track to determine if operational changes are required.