1. **Purpose**

The purpose of this policy is to articulate commitment by Kaiser Permanente Hawaii Region to control fraud, waste and abuse of its and others’ assets through prevention, detection and correction of any violation of a Federal or State law, regulatory requirement, contractual obligation or organizational policy or procedure.

2. **Scope**

This policy applies to all employees of Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Hospitals (KFH), and the Hawaii Permanente Medical Group, Inc. (HPMG), collectively “Kaiser Permanente Hawaii Region”. This will also include contractors, vendors, or other individuals or entities who provide direct patient care items or services, or perform billing, coding, or prescription benefit management.

3. **Definitions**

- **Fraud.** A deception or misrepresentation made intentionally or with reckless disregard for the truth made by an individual, knowing that the deception could result in some unauthorized benefit to himself/herself or other person or entity. Examples of fraud include embezzlement, false claims, kickbacks, bribery, false financial reporting, software piracy, credit card fraud, expense account fraud, identity theft, check fraud, false workers compensation claims, fraudulent vendor billing, member fraud, and mail fraud.

- **Waste.** Extravagant, careless, or needless expenditure of KP or government funds or the consumption of organizational assets that results from deficient or negligent practices, system controls, or decisions.

- **Abuse.** Intentional, wrongful, or improper use of KP or government resources, including but not limited to, misuse of position or authority that causes the loss or misuse of organization assets (e.g. funds, medical equipment, vehicles, computers, copy machines, etc.).

- **Knowledge.** Actual knowledge, deliberate ignorance of the truth, or reckless disregard for the truth.
• **Audit.** Refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

• **Monitoring Activities.** Refer to reviews that are repeated regularly during the normal course of operations. Monitoring activities may occur to ensure corrective actions are undertaken or when no specific problems have been identified to confirm ongoing compliance.

4. **Policy**

Kaiser Permanente Hawaii Region prohibits fraud, waste, or abuse in connection with the use of KP assets or government funds. This prohibition includes attempts and conspiracies to conduct such activity, as well as aiding, abetting, or concealing it. KP Hawaii promotes behavior that avoids fraud, waste or abuse and promotes operational accountability for the control of fraud, waste, and abuse.

5. **Provisions:**

5.1. **Regulatory Compliance.**

5.1.1. Kaiser Permanente Hawaii Region’s business, financial, and patient care practices shall comply with applicable Federal and State laws, Federal and State health care program requirements, including but not limited to the Anti-Kickback statute, the False Claims Act, Stark laws, and Centers for Medicare and Medicaid Services (CMS) fraud, waste and abuse regulations (Medicare Part D Chapter 9 Fraud, Waste and Abuse, Deficit Reduction Act of 2005).

5.1.2. Fraud, waste or abuse violations will be reported to the appropriate governmental agency.

5.2. **Prevention.** Kaiser Permanente Hawaii Region shall prevent fraudulent activity by complying with all applicable State and Federal statutes and regulations, and pertinent Kaiser National and Regional policies and procedures.

5.3. **Detection.** In collaboration with the National Compliance, Ethics & Integrity Office (“NCO” or “National Compliance Office”) Kaiser Permanente Hawaii Region is committed to detecting fraud, waste, and abuse by planning and developing activities, such as internal monitoring, auditing, data mining and analysis.

5.3.1. **Administrative Controls.** Effective internal controls shall be implemented at operational risk areas.
5.3.1.1. Employee Privileges and Duties shall be determined by managers, and the extent of those privileges should be related directly to position responsibilities (e.g., signing authority, issuance of company credit cards, use of computer and software passwords, keys, and cash handling and equivalents).

5.3.1.2. Other Administrative Controls shall be implemented to detect the abuse of privileges to access and use organization assets. Such controls include, but are not limited to, proper documentation, approval, and supervision.

5.3.2. Monitoring/Assessments and Audits

5.3.2.1. Internal monitoring/assessment and auditing shall be performed to validate fraud control measures and to ensure compliance with this policy, on an ongoing basis and as specific risks are identified.

5.3.2.1.1. The Internal Audit Services (IAS) will consider fraud-related risks and controls, identify system weaknesses that could create fraud risks, and recommend corrective action.

5.3.2.1.2. The NCO National Compliance Audit Team (NCAT) will audit on a for-cause basis to identify system weaknesses, recommend appropriate corrective action and monitor its implementation.

5.3.2.1.3. KP Hawaii Regional Compliance Office shall ensure that monitoring/assessments are conducted by the Region and corrective action plans are developed and implemented.

5.3.2.2. KP Hawaii Region shall develop a monitoring and auditing work plan that addresses the risks associated with KP assets, government funds (e.g. Medicare Part D, Medicaid and Quest benefits), and applicable Federal and State statutes and regulations.

5.3.2.3. External audits may be performed by an external entity if the NCO, IAS, or the Region so elects and if circumstances warrant.

5.3.3. At a minimum, the following activities will be avoided, and, if detected, will be ceased, corrected, and appropriately disclosed:
5.3.3.1. Billing for services or supplies that were not provided. This includes billing for services that were not actually furnished because the patients failed to keep their appointments;

5.3.3.2. Misrepresenting the patient’s diagnosis to justify the services or equipment furnished;

5.3.3.3. Altering claim forms to inappropriately obtain a higher payment amount;

5.3.3.4. Deliberately applying for duplicate payment, (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice);

5.3.3.5. Soliciting, offering, or receiving a kickback, bribe, or rebate, (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);

5.3.3.6. Unbundling or exploding charges inappropriately, (e.g., the billing of a multi-channel set of lab tests to appear as if the individual tests had been performed);

5.3.3.7. Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider;

5.3.3.8. Misrepresenting the services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services, such as:

5.3.3.8.1. Upcoding or the use of procedure codes not appropriate for the item or service actually furnished;

5.3.3.8.2. Billing for non-covered services as covered services, (e.g., routine foot care billed as a more involved form of foot care to obtain payment);

5.3.3.8.3. Participating in schemes that involve collusion between a provider and a beneficiary, or between a supplier and a provider and result in higher costs or charges to the Medicare program;

5.3.3.8.4. Using another person’s Medicare or Medicaid identification to bill for medical care rendered to a different person;

5.3.3.8.5. Billing procedures over a period of days when all treatment occurred during one visit; and
5.3.3.8.6. Billing based on group visits, (e.g., a physician visits a nursing home and bills for twenty (20) nursing home visits without furnishing any specific service to, or on behalf of, individual patients).

5.4. Fraud Control Communication, Education and Training

5.4.1. KP Hawaii shall maintain effective lines of communication associated with the prevention, detection and correction of fraud, waste, and abuse.

5.4.2. As a condition of employment, all employees will complete education and training related to the prevention, detection, and correction of fraud, waste and abuse at the time of hire and annually thereafter.

5.4.3. Various methods will be used to educate Health Plan, Medicare, and Quest enrollees on reporting compliance concerns, such as through KP Hawaii’s Customer Service Center. These concerns shall be referred to the Compliance Department.

5.5. Fraud Risk Assessments

All employees covered by the scope of this policy shall be subject to internal monitoring and auditing programs designed to identify and prioritize fraud, waste, and abuse risks. Risks shall be identified, prioritized, and addressed in monitoring and corrective action plans.

5.6. Reporting Fraud, Waste and Abuse

5.6.1. Internal Reporting. Individuals covered by this policy are required to report acts of fraud, waste and abuse either known or reasonably suspected. Such reports shall be entered, tracked, and monitored by the National Compliance Office TrakWeb/TrakEnterprise system. Use of the KP Compliance Hotline is strongly encouraged.

5.6.1.1. Refer to Regional Compliance Program policy 7334-12, “Responsible Reporting of and Responding to Compliance/Ethics Concerns” for details.

5.6.2. External Reporting. If a potentially reportable act of fraud, waste, and abuse occurs, appropriate stakeholders and the Regional Compliance Officer, or her/his designees, and designated legal counsel will be timely involved in analyzing and discussing the relevant issues. Self-reporting of acts of fraud, waste, and abuse is a critical element of an effective, compliant fraud, waste, and abuse control program.
5.6.2.1. Reporting to the Office of Inspector General (OIG) within 30 days after discovery of any ongoing investigation or legal proceeding known to Kaiser-Hawaii, as documented in the Regional Compliance Department policy number 7334-7, *Compliance with the Corporate Integrity Agreement*.

5.6.2.2. Reporting to the MEDIC (Medicare Drug Integrity Contractor) of any potentially reportable Medicare Part D Prescription Drug Benefit act of fraud, waste and abuse will be initiated by the Regional Compliance Office, then submitted through the NCO’s National Fraud Control Team. Referral to the MEDIC shall be within a reasonable period (but not more than 60 days after a determination that a violation may have occurred).

5.6.2.3. Reporting to Med-QUEST Division and the Medicaid Fraud Control Unit with the State’s Department of Attorney General of any potentially reportable Medicaid or MedQUEST act of fraud, waste and abuse will be initiated by the Regional Compliance Office.

5.6.2.4. Reporting to appropriate law enforcement and licensing agencies will occur as necessary.

5.7. **Investigations of Fraud, Waste and Abuse**

5.7.1. All credible allegations of fraud, waste, or abuse will be taken seriously and an appropriate investigation shall be conducted.

5.7.2. To the extent possible, investigations will protect anonymity and confidentiality of those involved and information related to the investigation will be shared only on a need-to-know basis.

5.7.3. Investigations accountabilities are delineated according to the Investigations Working Agreement maintained by the NCO.

5.7.4. Fraud, waste and abuse complaints will be recorded and tracked in the TrakWeb/TrakEnterprise system, and where reasonably possible, all complaints shall be investigated and closed within thirty (30) days of receipt.

5.7.5. Regional investigative staff will maintain an effective working relationship with the National Special Investigations Unit (NSIU), government investigators, and law enforcement.

5.8. **Corrective Action**
5.8.1. KP Hawaii managers must undertake effective measures for ensuring prompt responses to fraud, waste, and abuse and for developing corrective action initiatives relating to identified risks and offenses.

5.8.2. The Regional Compliance Officer will report identified risks to national and regional leaders to facilitate and monitor corrective action.

5.9. Disciplinary Action

5.9.1. Individuals who attempt to conspire to commit fraud, commit fraud, conceal fraud, aid and abet in the commission of fraud or who fail to report fraud are subject to appropriate corrective or disciplinary action up to and including termination.

5.9.2. Managers who fail to undertake basic responsibilities to prevent or detect fraud, waste, or abuse, or who fail to adhere to internal controls associated with the prevention of fraud, waste and abuse may be subject to appropriate corrective or disciplinary action, up to and including termination.

5.9.3. Employees covered by collective agreement will be subject to the discipline or corrective action process articulated in that agreement.

6. Standards

6.1 As part of Kaiser Permanente Hawaii Region’s commitment to limit opportunities for fraud, waste and abuse, Kaiser Permanente Hawaii Region understands that accurate documentation in patient medical records is an important part of an overall compliance program. As such, at a minimum, each medical record shall meet the following standards:

6.1.1 It will be complete and legible;

6.1.2 It will include, for each patient encounter, the reason for the encounter and relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression or diagnosis; plan for care and date and legible identity of the observer;

6.1.3 It will include the rationale for ordering diagnostic and other ancillary services;

6.1.4 Past and present diagnoses will be accessible to the treating and/or consulting physician;

6.1.5 Appropriate health risk factors will be identified;
6.1.6 The patient’s progress, response to and changes in treatment and revision in diagnosis will be documented; and

6.1.7 The CPT, ICD-9 and HCPCS codes reported on the claim will be supported by the documentation in the medical record.

7. Responsibilities

The Compliance Department shall be responsible for maintaining this policy and assuring that the content is accurate and current.

8. Maintenance

This policy shall be reviewed annually and revised as necessary.

9. References

• Medicare Carriers Manual § 14001 (CMS Pub. 14-3).
• Medicare Program Integrity Manual Chapter. 4 § 4.2.1 (CMS Pub. 100-8).
• 31 U.S.C. § 3729(b).
• Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse (42 C.F.R. § 423.504(b)(4)(vi)(H)
• Deficit Reduction Act of 2006, CMS
• Quest RFP-MQD-2002-004
• Kaiser Hawaii Policy 7334-7, Compliance with the Corporate Integrity Agreement
• National Compliance, Ethics & Integrity Office, Policy Number NCO-11 National Fraud, Waste and Abuse Control, 4/28/06
• Kaiser Hawaii Policy 7334-12: “Responsible Reporting and Responding to Compliance/Ethics Concerns”

10. Implementation
A. Effective Dates
This policy becomes effective upon approval by the approving authorities.

B. Distribution
- Upon approval, this policy shall be distributed to all process stakeholders and affected entities and departments.
- As applicable, affected entities, departments, and individuals may prepare and implement procedures consistent with this policy and as necessary conduct appropriate education to assure consistent and uniform implementation.
- This policy is accessible on the KP Hawaii Intranet.

11. Endorsement and Approval

| Contact Person(s): | Susan VonEssen, Regional Compliance Officer Sylvia Shimonishi, Manager, Pharmacy Compliance Maxine Derige, Director, Revenue Cycle | Date: 12/04/2006 |
| Endorsed by: | Compliance Operations and Scope of Practice Workgroup Medicare/Medicaid Managed Care Compliance Workgroup | Date: 12/04/2006 Date: 12/08/2006 |
| Approved by: | Compliance Committee | Date: 12/11/2006 |
| Next Review Date: | 12/11/07 |
| Replaces: | 7334-9, Prevention of Fraud and Abuse |