



# CORPORATE POLICY

Subject: <b>Fraud, Waste and Abuse Prevention &amp; Detection</b>		
Primary Department: Office of Business Ethics	Secondary Department(s): Corporate Investigations	Prior Policy Reference(s):
Effective Date of Policy: December 1, 2006	Date Policy Last Reviewed: July 21, 2008	Date Policy Last Revised: July 21, 2008
Plan CEO Approval/Signature:	Corporate Dept Sr Mgmt Approval/Signature:	Check Only One: Policy is Corporate Owned <input checked="" type="checkbox"/> Policy is Health Plan Owned <input type="checkbox"/>
<b>Check All That Apply:</b> Policy is applicable to: Corporate <input checked="" type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): <u>All Health Plans with the exception of New Jersey, New Mexico, and Ohio</u> (Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)		

**Purpose** To provide an outline of AMERIGROUP, its subsidiaries, officers, Directors and associates obligations and efforts to detect, mitigate and prevent fraud, waste and abuse under the requirements of the Corporate Compliance Program and individual State and Federal laws and regulations.

**Definitions**

**Abuse** – means provider practices that are inconsistent with sound fiscal, business or medical practices, and that result in the unnecessary cost to the government healthcare program, or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the healthcare program.

**Fraud** – an intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or to some other person.

**Knowingly** – meant that a person, with respect to information, has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information.

**Waste** – means the over utilization of services not caused by criminally negligent actions; waste also involves the misuse of resources.

**Policy** AMERIGROUP, its subsidiaries, officers, directors and associates have an affirmative obligation to participate in efforts to detect, mitigate and/or prevent fraud, waste and abuse within the health care system. Participation includes reporting suspected fraud, waste and abuse as described below.

**Responsibilities**

- 1) AMERIGROUP, as the cornerstone of its Corporate Compliance Program, requires annual acknowledgement and training of its associates on the Code of Business Conduct and Ethics, including but not limited

to the requirement to maintain confidentiality to the extent allowed under applicable laws, regulations and policy, of any person who files a compliance report and/or participates in a compliance investigation..

- 2) AMERIGROUP also requires its associates to complete the annual Fraud and Abuse training provided by the Corporate Investigations Department (CID).
- 3) AMERIGROUP maintains a mechanism for the reporting of suspected misconduct, fraud, waste and/or abuse as defined in the Fraud Plans.
- 4) AMERIGROUP's anti-fraud plans include the following steps:
  - a) Health Plan and Corporate Operational Departments review controls to mitigate financial risks, utilization, denials, authorizations, quality assurance, marketing compliance, case management, enrollment, credentialing and other functions related to the operation of the various health plans
  - b) The CID receives notice of and/or identifies suspicious activity and coordinates an investigation with the appropriate departments as outlined in the Fraud Plan
  - c) If fraud, waste or abuse is identified, the CID coordinates with the appropriate departments and state or federal agencies to report and resolve the fraud, waste or abuse.
  - d) Corrective actions are implemented as appropriate.
- 5) AMERIGROUP as part of its Corporate Compliance Program requires its associates and affiliates to abide by Federal and State laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the Federal and State false claims acts which establish liability for the following activities:
  - a) knowingly presenting or causing to be presented to an officer or employee of the United States and or applicable state government (Government) a false or fraudulent claim for payment or approval
  - b) knowingly making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Government
  - c) conspiring to submit a false claim (FL) or to defraud the Government by getting a false or fraudulent claim allowed or paid
  - d) possessing, having custody of, or controlling property or money used, or to be used by the Government and intending to defraud the Government or to willfully conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt
  - e) after being authorized to make or deliver a document certifying receipt of property used, or to be used by the Government and with the intent to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true (TN includes the following language "that falsely represents the property used or to be used")
  - f) knowingly buying or receiving as a pledge an obligation or debt,

- public property from an officer or employee of the Government or any person who lawfully may not sell or pledge the property; or
- g) knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government
  - h) knowingly makes, uses or causes to be made or used any false or fraudulent conduct, representation or practice in order to procure anything of value directly or indirectly from the Government (TN)
- 6) The federal government may impose penalties of not less than \$5,500 and not more than \$11,000 plus three (3) times the amount of damages sustained by the Government if there is a finding of a violation of the False Claims Act. The state false claims acts vary in the level and amount of penalties under the State false claims acts. The ranges are from \$2,000 to \$25,000.
- 7) The Government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government's investigation and if there are no criminal prosecutions, civil or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations.
- 8) The Government, or an individual, may bring a civil action for a violation of the applicable false claims act. If a person brings an action on behalf of the Government then that person may be entitled to a portion of any recovery under the applicable false claims act. The recovery is governed by the person's involvement in the claim and/or the litigation as well as whether the Government intervened in the litigation.
- 9) The Federal Government via the Office of Inspector General may also utilize administrative remedies for the submission of false statements and or claims which include administrative penalties of not more than \$5,500 per false claim as well determine whether suspension or debarment from the healthcare program is warranted.
- 10) AMERIGROUP as part of its Corporate Compliance Program also requires its associates and affiliates to abide by State laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the and Medicaid false claims acts which establish liability for the following activities:
- a) presenting, or causing to be presented, to the State a claim for payment under the Medicaid program knowing that such claim is false or fraudulent;
  - b) presenting or causing to be presented to the State a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;

- c) making, using or causing to be made or used, a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the State while knowing that such record or statement is false;
- d) conspiring to defraud the state by getting a claim allowed or paid under the Medicaid program while knowing that such claim is false or fraudulent;
- e) making, using or causing to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or to transmit money or property to the State, relative to the Medicaid program, knowing that such record or statement is false;
- f) knowingly applying for and receiving a benefit or payment on behalf of another person, except pursuant to the lawful assignment of benefits under the Medicaid program, and converting that benefit or payment to his or her own person use;
- g) knowingly making a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program; or
- h) knowingly making a claim under the Medicaid program for a service or product that was not provided.

- 11) The State may impose three times the amount of damages sustained by the government if there is a finding of a violation of the Medicaid False Claims Act. In Tennessee the state may impose a civil penalty between \$5,000 and \$25,000.
- 12) The Government, or an individual person, may bring a civil action in the name of the Government for a violation of a Medicaid false claims act.
- 13) Reporting obligations. AMERIGROUP maintains anonymous hotlines for the reporting of suspected fraud, waste and abuse. The reporting requirements are outlined in the Compliance Reporting policy. In addition to the anonymous hotlines, the CID maintains an email address at Corporate-Investigations on the internal email system or [corpinvest@amerigroupcorp.com](mailto:corpinvest@amerigroupcorp.com).
- 14) Non-retaliation: Protections against retaliation exist under AMERIGROUP policies as well as under federal and state laws for anyone providing a good faith report under the Corporate Compliance Program or filing and/or participating in litigation or other investigations under the various false claims acts.

## Exceptions

NY maintains the ability to obtain treble damages but does not maintain a private or individual right of action to bring a false claims action.

## References

FL Stat. § 68.081 et al.  
 NM Stat. § 27-14-1 et al.  
 NYC FCA § 7-801 et al., NYCLS Soc. Ser. § 145-b et al.

ORC § 5111.101  
SC Code § 38-55-170; § 43-7-60  
31 USC § 3729 et al., 3801 et al.  
TN Code 4-18-101 (FCA) and 75-1-181 (Medicaid FCA)  
VA Code § 8.01-216.1

**Related Policies  
and Procedures**

Compliance Reporting; Code of Business Conduct & Ethics; New Jersey  
Fraud, Waste and Abuse Prevention & Detection; Ohio Fraud Waste and  
Abuse Prevention & Detection; Fraud Waste and Abuse Prevention &  
Detection - NM

**Related Materials**

None