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Menasha, WI 54952
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Procedure1236 - Special Investigation Unit (SIU)

Lines of Business: All

Purpose: This guideline ensures that Network Health/Network Health Insurance Corporation (NHIC) commercial lines of business will consistently identify and address Fraud, Waste and Abuse (FW&A) activities, including safeguarding and dispersing funds appropriately in full compliance of the law and to continuously deliver quality health care at an affordable price.

Fraud: The intentional deception or misrepresentation that an individual knows or should know to be false or does not believe to be true and makes knowingly the decision to deceive could result in some unauthorized benefit to himself or some other person(s).

Waste: Defined as billing and information submitted for items or services where there was no intent to deceive or misrepresent, but the outcome resulted in an overpayment of funds.

Abuse: The unintentional deception or misrepresentation of an act knowingly made by an individual or entity where such act results in a benefit to the individual or entity.

Procedure: The focus of the Network Health/NHIC Special Investigations Unit (SIU) is to improve claim submission and billing practices in order to reduce FW&A activity, including safeguarding the funds entrusted to Network Health/NHIC and dispersing the funds appropriately.

The SIU will perform the following activities to protect Network Health/NHIC from potential FW&A, thereby preventing unnecessary cost to both Network Health/NHIC members and programs resulting from the reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

The SIU will monitor, review reports, and/or conduct audits in all areas vulnerable to potential FW&A. The areas include but are not limited to the following:

a) Duplicate claims
b) CPT billing and diagnosis code issues
c) Pharmacy
d) Laboratory billing activities
e) Enrollment/Disenrollment issues
f) Claims processing & billing schemes
g) Over/Under utilization issues
h) Waiver of cost sharing payments
i) Capitation issues
j) Foreign claim issues
k) Provider exclusion lists
l) Global days
m) Unbundling
n) Age/Sex
o) Inappropriate modifier usage, and
p) Other suspicious billing patterns

To promote timely investigations, Network Health/NHIC assigns a set number of working or calendar days during which the SIU is expected to complete a particular investigation. In summary:

- New cases will be opened within 3 working days of notification. A case number will be assigned and allegation information will be logged within the Quickbase (QB) SIU Tracking & Trending database. If emails are necessary or when setting up meetings in regards to SIU cases, each case will be referred to by the Intake form case number only.
- 6 working days are allowed from the time an offense is detected to develop an investigative plan;
- A total of 90 working days is allowed to perform the basic preparatory elements of an investigation. Network Health/NHIC allows 15 days each for the preliminary investigation, the selection of claims for review and preparing the request for medical records, if appropriate; and 45 days to receive the medical records from the provider or to conduct interviews and collect documentation regarding alleged improper enrollment practices;
- 30 calendar days are allowed for the review of medical records and/or other documents when necessary;
- 45 calendar days are allowed for additional active investigation;
- If necessary, a 30 working day timeframe is allowed for preparing the investigation for referral to law enforcement, litigation, or corrective action;
- 11 working days are allowed for the closure of an investigation.

At any point during the investigation, an expedited case may become necessary. If this were to occur the SIU representatives will immediately notify Network Health/NHIC's Claims Director and any other departments and/or agencies when applicable.

At any point during the investigation if it is determined that the case involves non-compliance with any state and/or federal guideline, the SIU will immediately report the case to the Compliance Department to determine an action plan for the remainder of the investigation; and the Compliance Director may notify Network Health's Medicaid line of business when applicable. For the Medicare line of business SIU will also report the case to the Vice President of Medicare with any pertinent information necessary for Medicare to conduct a separate investigation. If a case involves both commercial and Medicare lines of business the commercial SIU and Medicare will collaborate on the case.

When a case investigation is completed, the QB SIU Tracking & Trending and the Compliance Intake QB will be updated with a resolution and closed.

Transmittal of Confidential information:

Activities reported to or investigated by the SIU will be held confidential according to AHS confidentiality policies and procedures. This information may be released for furthering an investigation that may involve more than one insurance company, reporting to law enforcement, or other appropriate agencies. The referring source(s) will be redacted or de-identified to any transmittal outside of the SIU.

When SIU requires information internally (AHS & Network Health entities) they will provide a detailed coversheet with an expected due date for that department to return their portion of the case review to the SIU. At no time will the SIU refer a case to the AHS Legal Services Department if the provider under investigation is in fact an AHS provider.

Network Health/NHIC will maintain an open door policy toward any employee, recipient, provider, or other person wishing to report instances of external or internal suspicious activity. Person wishing to report any suspicious activity may submit the information to the attention of SIU Commercial Claims at Network Health, P.O. Box 568, Menasha, WI 54952.

Resolution or outcome of the case is not reported in writing due to confidentiality to the member or external informant. Internal communication of case investigation findings may include only a brief summary of the allegation (for example, case number, contracted or non-contracted provider, if the case was founded or non-founded, case referred to outside legal or other agencies, and if the case is open or closed).

Network Health/NHIC requires its third party administrator for pharmacy to implement safeguards to prevent fraudulent or abusive activity. If fraud or abuse is detected, third party administrator for pharmacy will conduct an immediate investigation and track the resolution for Network Health/NHIC reporting purposes.

Network Health/NHIC monitoring and auditing includes, but is not limited to the following:

- Auditing third party pharmacy administrator claims processing system on an annual basis.
- Obtaining and reviewing a SAS 70 audit from third party pharmacy administrator on an annual basis.
- Weekly review of members with unusually high quantities of narcotics and other drugs with high abuse potential.