Our Philosophy
Magellan takes **provider fraud, waste and abuse**

- We engage in considerable efforts and dedicate substantial resources to prevent these activities and to identify those committing violations.

- Magellan has made a commitment to actively pursue all suspected cases of fraud, waste and abuse and will work with law enforcement for full prosecution under the law.
Magellan promotes provider practices that are compliant with all federal and state laws on fraud, waste and abuse.

**Our Expectation** is - when deciding which services to order for their patients:
Our Policy
Magellan’s Compliance Program

Magellan has implemented a Comprehensive Compliance Program to ensure ongoing compliance with all contractual and regulatory requirements.

Magellan’s Compliance Program describes our comprehensive plan for the:

- Prevention
- Detection
- Reporting

of fraud, waste and abuse across various categories of healthcare related fraud.
The Elements of the Compliance Program

- Written Policies and Procedures
- Designation of a Compliance Officer and Compliance Committee
- Conducting Effective Training and Education
- Developing Effective Lines of Communication
- Auditing and Monitoring
- Enforcement Through Publicized Disciplinary Guidelines and Policies
- Dealing With Ineligible Persons
- Responding to Detected Offenses
- Developing Corrective Action Initiatives and Reporting to Government Authorities
- Whistleblower Protection and Non-Retaliation Policy
Magellan’s Procedure

Magellan does not tolerate fraud, waste or abuse either by:

- Providers
- Staff

Magellan’s programs are **wide-ranging** and **multi-faceted**, focusing on:

- Prevention
- Detection
- Investigation

... of all types of fraud, waste and abuse in government programs and private insurance programs.
Our policies in this area reflect that both Magellan and providers are subject to federal and state laws designed to prevent fraud and abuse in:

- Government Programs
- Medicare
- Medicaid
- Federally Funded Contracts
- Private Insurance
Magellan’s Practice

Magellan complies with all applicable laws:

- Federal False Claims Act
- State false claims laws
- Whistleblower protection laws
- Deficit Reduction Act of 2005
- The American Recovery and Reinvestment Act of 2009
- The Patient Protection and Affordable Care Act of 2010
- Applicable state and federal billing requirements for state-funded programs and federally funded healthcare programs

Medicare Advantage
State Children’s Health Insurance Program (SCHIP)
Medicaid
Other payers
What You Need to Do
Your Responsibility

- Comply with all laws and Magellan requirements.

- Ensure that the claims you (or your staff or agent) submit and the services you provide do not amount to fraud, waste or abuse, and do not violate any federal or state law relating to fraud, waste or abuse.

- Ensure that you provide to members services that are medically necessary and consistent with all applicable requirements, policies and procedures.
Magellan’s Expectations

- Ensure that all claims submissions are accurate.

- Ensure services are rendered according to all state and federal laws and meet all requirements of the DHH Service Definition Manual.

- Notify Magellan immediately of any changes or restrictions placed on your license.
  - Suspension
  - Revocation
  - Condition
  - Limitation
  - Qualification

- Notify Magellan upon initiation of any investigation or action that could reasonably lead to a restriction on your license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services.
Your Responsibility

Understand

Fraud
Waste
Abuse
Overpayment
What is Fraud?

**Fraud** means an **intentional deception** or **misrepresentation** made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person.

It includes any act that constitutes fraud under applicable federal or state law.
What is Waste?

**Waste** means *over-utilization* of services or other practices that result in:

- **Unnecessary**
- **Costs**
What is Abuse?

Abuse means provider practices that are inconsistent with sound that result in an unnecessary cost to government-sponsored programs and other healthcare programs/plans in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

It also includes recipient practices that result in unnecessary costs to federally and/or state-funded healthcare programs, and other payers.
What is Overpayment?

**Overpayment** means *any funds* that a person receives or retains to which the person, after applicable reconciliation, is not entitled under such healthcare program.

It includes any amount that is not authorized to be paid by the healthcare program whether paid as a result of:

- Inaccurate or improper cost reporting
- Improper claiming practices
- Fraud
- Abuse
- Mistake
Examples of Fraud, Waste, Abuse and Overpayment

- Billing for services or procedures that have not been performed or have been performed by others
- Billing for services for which a provider is not qualified to provide
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act.
- Routinely waiving patient deductibles or co-payments
- Providing or ordering medically unnecessary services and tests based on financial gain
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient)
Other Examples of Fraud, Waste, Abuse and Overpayment

- Providing services over the telephone or Internet and billing using face-to-face codes
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Treating all patients weekly regardless of medically necessity
- Routinely maxing out of members’ benefits or authorizations regardless of whether or not the services are medically necessary
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals)
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs
- Lying about credentials, such as degree and licensure information
Your Responsibilities

Cooperate with Magellan’s investigations

Magellan’s Expectation is that you will fully cooperate and participate with its fraud, waste and abuse programs.

This includes, but is not limited to:

- Permitting Magellan access to member treatment records
- Allowing Magellan to conduct on-site audits or reviews
- Magellan also may interview members as part of an investigation, without provider interference.
Your Responsibilities (Continued)

Report suspected fraud, waste, abuse and overpayments

Magellan expects, providers and their staff and agents to report any suspected cases of fraud, waste, abuse or overpayments.

Magellan will not retaliate against you if you inform:
- Magellan
- The federal government
- State government
- Any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.
How to Report Suspected Cases of Fraud, Waste, Abuse or Overpayments
**Methods for Reporting**

Reports may be made to Magellan via one of the following methods:

- **Corporate Compliance Hotline:** 1-800-915-2108
- **Compliance Unit Email:** Compliance@MagellanHealth.com
- **Special Investigations Unit Hotline:** 1-800-755-0850
- **Special Investigations Unit Email:** SIU@MagellanHealth.com
- **DHH Provider Fraud Line:** 1-800-488-2917

Reports to the corporate compliance hotline may be made 24 hours a day/seven days a week:

- The hotline is maintained by an outside vendor.
- Callers may choose to remain anonymous.
- All calls will be investigated and remain confidential.
Reporting Suspected Cases of Fraud, Waste, Abuse or Overpayments
Self-Disclosure Reporting

With regard to Medicare, Medicaid, SCHIP and other federally funded healthcare programs:

- Providers can disclose self-discovered evidence of potential fraud, waste, abuse and overpayments to federal and state regulatory agencies with oversight of the applicable healthcare program.

- Providers can also self-disclose information to Magellan. According to the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) website.

- Providers who wish to voluntarily disclose self-discovered evidence of potential fraud to OIG may do so under the Provider Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative litigation.

- Additional information regarding the HHS-OIG Provider SDP is available at https://oig.hhs.gov/compliance/self-disclosure-info/index.asp.

- States also have state-specific Self-Disclosure Protocols. Additional information regarding state-specific procedures for Provider Self-Disclosures is typically available by visiting the state’s Office of Inspector General website or the website of other applicable state regulatory agencies with oversight of the state’s Self-Disclosure Protocol.

With regard to non-government funded healthcare programs:

- Providers can disclose self-discovered evidence of potential fraud, waste, abuse and overpayments to Magellan and other applicable state regulatory agencies including but not limited to the state’s insurance agency.
for reporting suspected cases of fraud, waste, abuse or overpayments to Magellan, the federal government, state government, or any other regulatory agency with oversight authority.

- Federal and state law also prohibits Magellan from discriminating against an employee in the terms or conditions of his or her employment because the employee initiated or otherwise assisted in a false claims action.

- Magellan also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.
What Magellan Will Do
Magellan’s Responsibility

Implement and regularly conduct fraud, waste and abuse prevention activities that include:

- **Extensively monitor and audit provider utilization and claims to detect fraud, waste and abuse**
- **Actively investigate and pursue fraud and abuse and other alleged illegal, unethical or unprofessional conduct**
- **Report suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations**
- **Cooperate with law enforcement authorities in the prosecution of healthcare and insurance fraud cases**
- **Verify eligibility for members and providers**
- **Utilize internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/Medicaid and other federally funded healthcare programs**
- **Train employees annually on Magellan’s Corporate Code of Conduct**
- **Make the Magellan Provider Handbook available to our providers**
Provider Exclusion from Federally or State-Funded Programs
Our Philosophy
Magellan’s Philosophy

- Magellan promotes provider compliance with all federal and state laws on provider exclusion.

- The U.S. Department of Health and Human Services (HHS) through the Office of Inspector General (HHS-OIG) can exclude individuals and entities from participating in federally funded health care programs.
According to the HHS-OIG, the basis for exclusion includes:

1. Convictions for program-related fraud and patient abuse
2. Licensing board actions
3. Default on Health Education Assistance Loans

The effect of an OIG exclusion is that no Federal health care program payment may be made for any items or services furnished by an excluded person or at the medical direction or on the prescription of an excluded person.
Our Policy
Magellan’s Policy

Magellan’s policy is to ensure that excluded individuals/entities are not hired, employed or contracted by Magellan to provide services for any of Magellan’s federally and state funded healthcare contracts.
What You Need to Do
Your Responsibilities

Your responsibilities as required by the Centers for Medicare and Medicaid Services (CMS); you must take the following steps to determine whether your employees and contractors are excluded individuals or entities:

1. Screen all employees
2. Search the HHS-OIG LEIE
3. Immediately report
4. Check each month to ensure
5. Immediately notify Magellan
6. Identity all persons with an ownership or control interest
7. Certain business transactions
8. Any person with an ownership or control interest