Policy and Procedure		
SUBJECT: Fraud, Waste and Abuse Program	DEPARTMENT: **Regulatory Compliance, Risk Management and Government Affairs**	
ORIGINAL EFFECTIVE DATE: **09/00**	DATE(S) REVIEWED/REVISED: 07/02, 09/08, 12/08, 08/09, 04/10, 02/11, 05/12, 02/13, 04/14, 04/15, 04/16, 04/17, 04/18, 07/19, 07/21, 05/22, 10/23, 09/24, 11/25	
APPROVED BY: Chief Compliance and Risk Officer	NUMBER: **RA 25**	PAGE: **1 of 13**

SCOPE:
Providence Health Plan and Providence Health Assurance, as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Fully Insured					
Individual	Small Group	Large Group	Self-Insured	Medicare	Medicaid
☐ Oregon On Exchange	☐ Oregon On Exchange (SHOP)	☐ Oregon	☐ ASO	☐ Medicare Advantage	☐ Medicaid
☐ Oregon Off Exchange	☐ Oregon Off Exchange (SHOP)	☐ Washington	☐ PBM	☐ Medicare Supplement	
				☐ Medicare Advantage – D-SNP	
☐ Washington Off Exchange					
☒ APPLIES TO ALL ABOVE LINES OF BUSINESS					

POLICY:
Companies are committed to the prevention and detection of (FWA). The purpose of this policy is to establish a FWA program designed to prevent and detect potential fraud and abuse occurrences. It also establishes a process for reporting and responding to potential fraud and abuse. Companies, as part of Providence St. Joseph Health, also has System wide policies regarding an Integrity Statement and Guidelines, Code of Conduct, and an established Consulting and Audit Service. These policies incorporate the regular and effective education and training programs for all affected caregivers and providers.

It is the policy of Companies to follow all state and federal False Claims Acts, and to educate all existing caregivers, agents, and contractors to the policies and procedures intended to meet those requirements, and to educate new caregivers/agents upon hire /engagement. Companies expect caregivers, agents and contractors who are involved with the creation, filing and processing of claims for payment for services will use only true, complete and accurate information about the claim.

DEFINITIONS:

Fraud:

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18U.S.C. § 1347.

Waste:

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse:

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Abuse (of patient):

Physical abuse, sexual abuse, neglect, or inappropriate treatment of a patient.

Federal False Claims Act (31 USC 3729-33)**:**

Makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowingly" means that the person or organization:

- Knows the record or claim is false, or
- Seeks payment while ignoring whether or not the record or claim is false, or
- Seeks payment recklessly without caring whether or not the record or claim is false

More specifically, the Federal False Claims Act applies to any person or organization that does any of the following:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to a federal government caregiver
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government
- Conspires to get a false or fraudulent claim allowed or paid to defraud the federal government

- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money to the federal government
- Acts in deliberate ignorance of the truth or falsity of the information
- Acts in reckless disregard of the truth or falsity

A person who knows a False Claim was filed for payment can file a lawsuit in Federal Court on behalf of the government and, in some cases, receive a reward for bringing original information about a violation to the government's attention. Some states have a False Claims act that allows a similar lawsuit in court if a false claim is filed with the state for payment, such as under Medicaid or Workers Compensation. Penalties are severe for violating the federal False Claims Act.

The Federal False Claims Act imposes two types of liability:

- The submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the government any damages and even if the claim is rejected
- The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim

Under the Federal False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the government's damages plus civil penalties of $11,181 to $22,363 per false claim. A detailed description of the federal false claims act is located on the Regulatory Compliance and Government Affairs website which is accessible to all caregivers.

Medicare Advantage Part D:
Medicare Part D is the prescription drug benefit which is part of the Medicare program. Along with the benefits of this program come opportunities for potential FWA. Companies have additional policies and procedures regarding the detection, prevention and correction of FWA specific to the prescription drug benefit under Medicare Part D. See Pharmacy Policy on 096 Pharmacy Department Monitoring and Auditing Program and 021 Detection and Prevention of FWA.

Program Integrity Audit:
"Program Integrity Audit" means: (i) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State Plan approved under Title XIX of the Social Security Act (or under any waiver of such plan approved under Section 1115 of the Act) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have the potential for resulting in an expenditure of funds under Title XIX in a manner which is not intended under the provisions of Title XIX.; or (ii) Auditing of claims for payment for items or services furnished, or administrative

services rendered, under a State Plan under Title XIX to ensure proper payments were made. This includes cost reports, consulting contracts, and risk contracts under section 1903(m) of the Act; or (iii) A review conducted to identify if Overpayments have been made to individuals or entities receiving federal funds under Title XIX (42 CFR 455.232).; or (iv) Any combination of the above. An Audit is not solely a review of compliance with contract, OAR, or CFR requirements.

Special Investigations Unit:
Companies will operate an effective program to control (FWA) including policies and procedures to identify and address FWA. An SIU is an investigation unit, separate from the compliance department, responsible for conducting surveillance, interviews, and other methods of investigation relating to potential FWA. Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and which includes at least one employee who reports directly to the Chief Compliance Officer. Such professional employees must be dedicated solely and exclusively to the prevention, detection, and investigation of fraud and abuse in Contractor's Medicaid program. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor. Contractor must demonstrate continuous work towards increasing qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees. The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care Providers. The team may employ, or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases. Contractor's system for training and education must provide all information necessary for its employees, Subcontractors and Participating Providers to fully comply with the Fraud, Waste, and Abuse requirements of this Contract. All such training and education must be specific and applicable to Fraud, Waste, and Abuse in Medicaid program. All training must include Medicaid-specific referral and reporting information and training regarding Contractor's Medicaid Fraud, Waste, and Abuse policies and procedures.

Procedures to routinely verify whether services that have been represented to have been delivered by Participating Providers and Subcontractors may be received by Members, to investigate incidents where services were not delivered or where Member paid out of pocket for services, and to collect any associated Overpayments. Such verification of services may be made by: (i) mailing service verification letters to Members, sampling, or other methods. Companies SIU will not perform law enforcement activities and will refer all matters indicative of FWA to the I-MEDIC or law enforcement. External Audit Investigator(s) will conduct fraud waste and abuse investigations within guidances such as Company policies, industry guidelines, and departmental procedures.

State Laws

Oregon law (ORS 165.690 & 165.692) states:

A person commits the crime of making a false claim for health care payment when the person:

(1) Knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or

(2) Knowingly conceals form or fails to disclose to a health care payer the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled.

Additional Oregon laws:

ORS 411.670 to 411.690 (submitting wrongful claim for payment of public assistance or medical assistance; Liability of person wrongfully receiving payment of public assistance or medical assistance; amount of recovery; rules Claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery); ORS 646.605 to 646.656 (unlawful trade practices); ORS chapter 162.055 to 162.085 (perjury and related offenses) crimes related to perjury, false swearing and unsworn falsification); ORS chapter 164.015 to 164.140 (theft and related offenses) crimes related to theft); ORS chapter 165 (offenses crimes involving fraud or deception), including but not limited to ORS 165.080 (falsification of falsifying business records) and ORS 165.690 to 165.698 (false Claims for health care payments); ORS 166.715 to 166.735 (racketeering – civil or criminal); ORS 659A.199200 to 659A.236224 (whistleblowing); ORS 659A.230 to 659A.233 (whistleblowing); OAR 410-120-1395 to 410-120-1510 (program integrity, recovery of overpayments to providers, provider sanctions, fraud and abuse); and common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.

Washington law (RCW 48.80.030) states:

Making false claims, concealing information — Penalty — Exclusions.

(1) A person shall not make or present or cause to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false.

(2) No person shall knowingly present to a health care payer a claim for a health care payment that falsely represents that the goods or services were medically necessary in accordance with professionally accepted standards. Each claim that violates this subsection shall constitute a separate offense.

(3) No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation.

(4) No person shall conceal the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care

payer for a specified health care service. A person shall not conceal or fail to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.

(5) No provider shall willfully collect or attempt to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payor to which the provider is a party.

(6) A person who violates this section is guilty of a class C felony punishable under chapter 9A.20 RCW.

(7) This section does not apply to statements made on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its caregivers. [1990 c 119 § 11; 1986 c 243 § 3.]

PROCEDURE:

A. Companies maintain the following activities and controls within various departments to promote effective utilization of healthcare resources and/or identify potential fraud, waste, or abuse occurrences may include but not limited to:
    a. Information system claims edits such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization.
    b. Post- processing review of claims and other claim analytics.
    c. Practitioner credentialing and re-credentialing policies and procedures, including on-site reviews. Companies have Policies and Procedures through our Credentialing Department that prohibits the hiring or retention of suspended or terminated providers. To prevent payments to excluded individuals, monthly downloads from CMS, HHS OIG LEIE, and the SAM/EPLS are utilized to check whether current providers are on the list, and action would be taken to discontinue participation with Companies. Companies will not pay providers who are suspended, terminated or excluded by Medicare, Medicaid or SCHIP except for Emergency services. If unauthorized payments are made to any excluded providers, Companies shall recover those payments from the provider (see policy RA 49 Excluded Providers and Individuals).
    d. Prior authorization policies and procedures (member eligibility verification, medical necessity, appropriateness of service requested, covered service verification, appropriate referral).
    e. Utilization management practices, such as prior authorization, concurrent review, discharge planning, retrospective review.

f. Claims review such as appropriateness of services and level(s) of care, reasonable charges, and potential excessive over-utilization.
g. Overpayment Recovery (OPR), Coordination of Benefits (COB) and Third Party Liability (TPL) promoting appropriate payment rules, seeking reimbursement for claims overpayments
h. As circumstances warrant, referrals to or from committees such as Compliance & Risk Committee, Practitioner Escalation Review Team (PERT) Committee, Medical Expense Report Review (MER), Managed Care Savings/Payment Integrity & Affordability Committee, Medical Policy Committee, and Pharmacy & Therapeutics Committees.
i. Practitioner and member handbooks/websites language regarding the reporting of potential FWA.
j. Caregiver training regarding potential FWA occurrences, detection and reporting. Company provides and requires that all caregivers, managers, directors and chief executives take an annual training specific to Medicare Advantage, Medicaid and state FWA regulations. Such training occurs at least annually and is a part of the orientation for new caregivers.
k. Training of contracted providers. First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies(DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.
l. As appropriate referrals from the Appeal and Grievance department of practitioner and member complaints and grievances.
m. With respect to OHP (Oregon Health Plan) members, confirmation with a sample of the population, that services as billed by the provider were actually received by the member. As part of this process, Company sends member verification letters to OHP members and performs follow- up if member reports concerns.
n. Medicaid Data Validation Audits sampling across all OHP claims to verify accuracy with source documentation, if errors found, education and refunds as appropriate occurs.

B. Applicability of the Policy to Agents and Contractors
   a. Companies agents and contractors are required to comply with all policies and procedures. Company provides agents, contractors and subcontractors with compliance training, FWA training, its written standards of conduct, as well as their written policies and procedures which:
      i. Promote the commitment to compliance by the agent or contractor;

ii. Requires the agent and contractor to address specific areas of potential fraud, such as claims submission process, and financial relationships with its caregivers and permitted subcontractors;

iii. Provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any Oregon/Washington laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 USC 1320a-7b;

C. Caregiver Required Reporting Suspected FWA

a. Each caregiver, agent, and contractor has an obligation to report suspected fraud, waste, or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, provider, or member. Program noncompliance and FWA may occur at the level of the sponsor, company or its affiliates/FDRs. It may be discovered through a hotline, a website, an enrollee complaint, during routine monitoring or self-evaluation, an audit, or by regulatory authorities. Regardless of how the noncompliance or FWA is identified, any cases of potential fraud waste and/or abuse will be identified and referred to the Director of Payment Integrity following Referral Policy (See Policy and Procedure 14.0 Referral Policy). When a caregiver suspects fraud, waste or abuse, such caregiver should submit an report through the methods available to the SIU. Any potential Fraud Waste or Abuse occurrence, identified by a caregiver during the course of performing their duties, may be initially reported to the department supervisor. The supervisor may assist the caregiver in creating a referral to the Payment Integrity Director of Payment Integrity following Referral Policy (See Policy and Procedure 14.0 Referral Policy).

b. Agents, contractors or other parties wishing to report suspected fraud waste or abuse may submit an anonymous report through several methods

i. Reporter can call the Special Investigations Unit at 503-574-8505 or toll-free at 888-233-4101.

Or mail a letter to:
Special Investigations Unit
Providence Health Plans
P.O. Box 3150
Portland, OR 97208-3150

Or complete the External Referral Form (PDF) located at
http://www.providence.org/healthplans/members/fwa.aspx

Print it and send it by mail or secure fax at 503-574-8142. This will ensure the confidentiality of the report.

D. Fraud, Waste, and Abuse Investigations
   a. The following summary provides an overview of the steps taken when the SIU receives a report suspected fraud, waste or abuse, though additional steps may be necessary depending upon the circumstances of each case.
   b. Member or Provider Fraud- When member fraud, waste or abuse is reported, upon receipt of referral or other communication, the SIU shall perform an audit of the relevant materials to determine if a preliminary case of fraud, waste of abuse is detected.
   c. As part of this audit, the SIU may:
      i. Review member or provider demographic information.
      ii. Review member claims or other claims submitted by the provider to identify existence and scope of possible fraudulent activity.
      iii. Contact other departments for relevant information or obtain necessary information from outside sources, including the billing or treating provider.
      iv. Analyze encounter data, billing, medical/pharmacy coding or other information as circumstances warrant to develop data for further analysis and decision.
      v. The SIU may determine that a desk audit or onsite audit is necessary based on the egregiousness of the material facts.
      vi. Review investigation information and make referral to an outside entity, as appropriate or required. If the circumstances and data warrant referral to an outside entity, the SIU will forward information to the appropriate city, county, state or federal regulatory agencies, or forward OHP plan information to the DMAP Medicaid Fraud Control Unit, the DHS Audit Unit or the appropriate state or federal regulatory agency. If circumstances and data do not warrant referral, a summary of the non-referral decision factors will documented and the case will be closed.
      vii. Provide feedback to originator and management, as appropriate.

E. Caregiver, Agent or Contractor FWA - If a caregiver, agent or contractor suspects that an Company caregiver has engaged in fraud, waste or abuse, the individual should immediately

report the incident to the caregiver's Supervisor (if known) or to the Companies Human Resources department. Such reports may also be submitted to the External Audits Director of Payment Integrity following Referral Policy (See Policy and Procedure 14.0 Referral Policy).

a. Complete investigation, interviews, as appropriate will be conducted.
b. Appropriate disciplinary action, up to and including immediate termination of employment, is taken against caregivers who have violated FWA policies, applicable statutes, regulations, or Federal or State health care program requirements.

Designated Compliance Officer:
Company employs a Director of Medicare Compliance and Director of Payment Integrity who report to the Chief Compliance and Risk Officer. The Chief Compliance and Risk Officer is charged with the responsibility of operating and monitoring the FWA processes, and has direct access to management personnel of all operations of the company, to the Chief Executive Officer and to the Board of Directors. The Chief Compliance and Risk Officer shall report any material issues of FWA to the Board. The Compliance Officer must be a caregiver of the Company.

Non-Retaliation/ Non-Retribution:
State and federal law protect those who report against retaliation (discharge, demotion, suspension, threats, harassment, or other manner of discrimination) because of the lawful acts of the caregiver in reporting under the False Claims Act. Companies prohibit retaliation against any workforce member for making a report of their concerns about actual or potential wrong-doing. See PH&S Policy PROV-HR-419.

Patient/Member Abuse:
Companies will comply with all patient abuse reporting requirements and fully cooperate with the state for the purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. Companies shall ensure all Subcontractors comply with this provision. Abuse includes but is not limited to: hitting or kicking patients; sexual abuse or assault; providing excessive or unnecessary services; withholding necessary treatment, billing Medicaid patients for covered services, or higher rates than non-Medicaid for non-covered services.

Confidentiality:
When conducting investigations the SIU has the right to access practitioner, member, and caregiver records necessary to audit or conduct an investigation into allegations of fraud, waste, or abuse as stated in the provider contract, or if non-contracted through the member's contract with Companies. This right to audit or inspect does not extend to information subject to legal privilege.

All information identified, researched, or obtained for or, as part of a potential fraud and abuse audit is considered confidential by Companies. Any material used in the audit of a potential occurrence of fraud or abuse will be used only by the appropriate people and only for the purposes of the audit and/or referral to the NBI MEDIC, MFCU/ Health Share (for OHP) and other appropriate regulatory and oversight agencies. All caregivers must sign a confidentiality agreement at the beginning of employment, and at annual reviews. The information and records obtained and used during the course of any audit will be maintained according to established Company confidentiality policies, and in compliance with all state and federal laws regarding confidentiality.

Payment Integrity/External Audits/SIU treats all information received confidentially, to the extent allowed by law. Any caregiver, member, provider, citizen, contractor, vendor, or other interested party who has observed or suspects dishonest or fraudulent activity should notify the Fraud Hotline immediately. Persons observing or suspecting dishonest or fraudulent activity should not attempt to personally conduct an investigation related to such activity.

For the Purposes of This Policy, Examples of Fraud, Waste and Abuse Could Include, But Are Not Limited To:

Unintentional billing errors - Provider offices may on occasion unknowingly bill a service that is not accepted standard of practice or is incorrect by billing or coding standards. These standards may include references to CPT, ICD-9-CM, HCPCS, Medicare Carriers Manual, CPT Assistant, Coding Clinic, specialty society guidance, National Correct Coding Initiative, etc.

Abusive practices – Abusive practices are those that directly or indirectly result in unnecessary costs to the health plan and its customers. This could include improper payment, payment for services that fail to meet accepted standards of practice, that are medically unnecessary, or for which there is no legal entitlement. Typically, the physician or other health care professional has not knowingly and willfully misrepresented facts to obtain payment.

Fraudulent practices – Fraudulent practices relate to intentional deception or misrepresentation to obtain some benefit, such as payment for medical services. Intent is an essential element in fraudulent billing.

Additional examples of potentially fraudulent or wasteful practices (Fraud requires intent):

- Falsifying provider information / billing incorrect provider of service
- Falsifying member information
- Billing for services not actually provided
- Billing for higher paying services when a less extensive service was provided
- Misrepresenting services as medically necessary and/or as covered benefits

- Billing inappropriate numbers of units
- Billing inappropriate diagnoses in order to receive payment
- Billing services that are excessive in scope, duration or frequency
- Providing substandard care that is not consistent with current standards of practice
- Paying or receiving remuneration or kickbacks for referrals
- Violation of federal and state statutes
- Billing for services that are not medically necessary
- Balance billing a member for provider write-off portion of a covered service/balance billing Medicaid members for Medicaid covered services
- Paying or receiving remuneration or kickbacks for referrals
- Violating of federal and state statues relating to self-referrals
- Intentionally billing for services in duplicate
- Billing for services provided by unlicensed or otherwise ineligible practitioners
- Purposeful altering, falsification or destruction of clinical record documentation for the purpose of artificially inflating or obscuring compliance rating and/or collecting payments not otherwise due
- “Unbundling”, “fragmenting” or “code gaming” in order to manipulate the CPT codes as a means of increasing reimbursement
- Failure to document medical records adequately
- Inappropriate billing practices such as misuse of modifiers
- Failure to comply with participation agreement, payment rules
- Concealing patient’s misuse of health insurance card
- Routinely waiving deductibles and copayments for Medicare payments
- Retention of payments to which the provider is not entitled (e.g.; duplicate payments, overpayments due to inaccurate contracted rate, overpayments due to other primary liability for claim, etc.)

Medicare Part D Fraud Waste Abuse Examples:

Some of the potential Part D FWA violations include:

- Billing for services not furnished and/or drugs not provided
- Billing non-covered prescription as covered items
- Billing for expired drugs
- Dispensing without a prescription
- Billing for recycled prescription drugs
- Billing for brand when generics are dispensed
- Altering scripts or data to obtain a higher payment amount
- Misrepresentations of dates, descriptions of prescriptions or services

Common examples of Part D abuse are:

- Performance of services considered to be medically unnecessary
- Failure to document medical records adequately
- Unintentional, inappropriate billing practices such as misuse of modifiers
- Failure to comply with participation agreement

REFERENCES:

Medicare Advantage and Part D Fraud Handbook Version 2.0 May 2015
Health Share of Oregon Policy Number: CORP-09 FRAUD, WASTE AND ABUSE PREVENTION AND DETECTION
Health Share of Oregon Policy Number: OPS-03: RECOVERY OF OVERPAYMENTS FROM PROVIDERS
Health Share of Oregon Policy Number: OPS-07: EXCLUDED PROVIDERS, INDIVIDUALS AND ORGANIZATIONS
Prescription Drug Benefit Manual Chapter 9 – Compliance Program Guidelines
Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines Section 6032 of the Deficit Reduction Act of 2005, 42 USC § 1396a(a)(68)
42 CFR 455.20
42 CFR 433.116 (e)(f)
31 USC 3729-3733 federal False Claims Act
31 USC Chapter 38 Administrative remedies for false claims and statements
Other applicable State and Federal laws
PI 14.0 Referral Policy
RA 49 Excluded Providers Policy
PI 26.0 Claims Coding Audits Policy
Providence St. Joseph Health Integrity and Compliance Program Description
Providence Code of Conduct
Providence St. Joseph Health Policies and Procedures:
PROV-HR-419 (Non-Retaliation/ Non-Retribution), PROV-ICP-700 (System Integrity), PROV-ICP-705 (Corrective Actions and Sanctions), PROV-ICP-711 (Fraud and Abuse Prevention and Detection)
Current Procedural Terminology (CPT)
HCPCS Procedure Coding System
International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)