Denver Health Medical Plan's Fraud, Waste Abuse Program

Program Description:

Denver Health Medical Plan ("DHMP") is committed to conducting its business operations in compliance with ethical standards, internal policies and procedures, contractual obligations and all applicable federal and state statutes, regulations and rules, including those pertaining to the Centers for Medicare and Medicaid Services ("CMS") Part C and D programs; Colorado Department of Health Care Policy & and the Office of Inspector General ("OIG"). This Fraud, Waste and Abuse ("FWA") Program Description applies to all lines of business in which Denver Health Medical Plan is involved. Denver Health Medical Plan 's commitment to guard against fraud, waste and abuse extends to its own internal business operations, as well as, its oversight and monitoring responsibilities related to its contracted entities (including First-tier, Downstream and Related Entities).

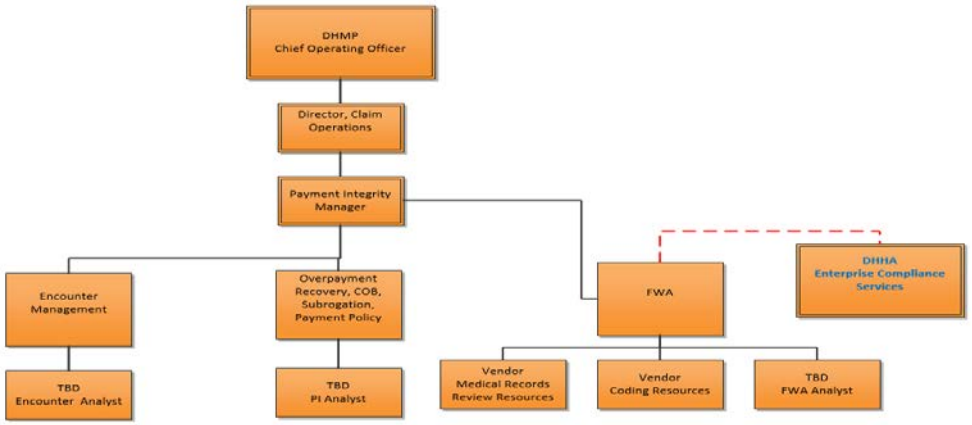
DHMP has formalized its fraud, waste and abuse activities through a comprehensive FWA Program.

Structure: The Plan's FWA activities will reside in the Plans' Payment Integrity Unit which is responsible for the following activities:

- Fraud Waste and Abuse detection
- Encounter Management
- Claims recovery
- Subrogation
- Coordination of Benefits

The FWA department will consist of the following personnel which will report to the Director of Claims and up to the Chief Operating Officer with a dotted line to Compliance.

- Payment Integrity Manager
- FWA Analyst
- Payment Integrity Analyst
- Encounters Management Analyst



DHMP Detect

DHMP's proprietary FWA tool called DHMP Detect is in development. This tool identifies claims that have characteristics of Fraud, Waste or Abuse based on predetermined schemes developed and or used by DHMP. The tool also utilizes the plans' claims editing software which focuses on prepayment detection on coding edits among which are NCCI driven. To augment this, DHMP has developed eight such schemes and will update and modify them as the program matures. The Plan has joined CMS's HPP and the National Heath Care Fraud, Waste and Abuse Association to learn of additional fraud schemes which it will incorporate into its dashboard to assist with FWA detection.

- **Scheme 1** - Providers who constantly have claims denied or adjusted as a result of coding review.
- **Scheme 2** - Providers who submit an abnormally high number of corrected claims.
- **Scheme 3** - Providers who submit claims that based on comparisons between patient volumes for similar professional claims have abnormally high reimbursements or submit claims for unusually high numbers of procedures based on specialty and practice size.
- **Scheme 4** - A list of providers with a risk ranking of Low, Moderate or High based on high claim volume and reimbursement higher than the average of other providers in their peer group
- **Scheme 5** – A list of providers who have never billed a lower level E&M code but have a higher E&M code in claim history.
- **Scheme 6** - A list of providers who have bill View 6 - Members receiving medications billed on both the medical and pharmacy side.
- **Scheme 7**- A listing of members receiving DME items that exceed the item's frequency limit.
- **Scheme 8** - A list of hospitals who have submitted multiple inpatient claims that are not compliant within the 30-day re-admission requirement

Data:

Schemes are based on claims paid by the health plan within a 3-year time frame and will include all DHMP LOB and all providers who provide services to DHMP members. Claims data used in the schemes will consist of claims paid through DHMP claims platform QNXT and from any of its vendors responsible for providing health care services to members including Pharmacy and Dental. DHMP requires that these vendors provide claims data monthly to DHMP and that data is housed in the DHMP data warehouse. The DHMP data warehouse is managed by its information systems (IS) department.

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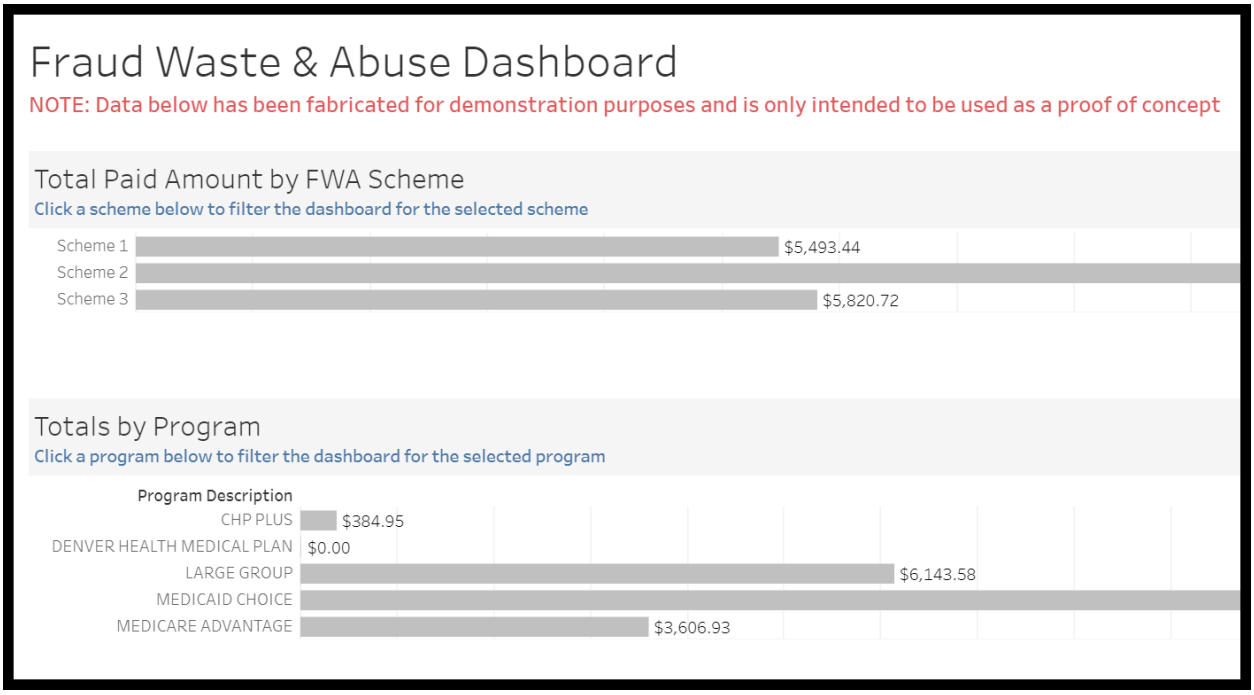
DHMP Detect:

Denver Health Medical Plan (DHMP) Detect is the proprietary data dashboard that identifies providers for review based on the predetermined schemes coded into the program. The dashboard is a user-friendly tool that is automatically updated monthly with paid claims information.

*Demo: Used for display purposes only; tool still under development and may change



Process:

The tool will identify providers and claims for review. The FWA analyst will be responsible for retrieving a statistically valid sample of claims identified in each scheme. If the number of claims identified is less than 50 the analyst will review all claims identified.

Cases on each provider identified by the tool will be opened in the plans' claims platform, QNXT, which houses provider data, member information including eligibility and processed medical claims among other things.

1) The FWA analyst will review the dashboard weekly to identify providers identified by the tool for review
2) The FWA analyst will download the provider claims report and complete the following:
    a. Identify the provider's name and TIN and enter a case in Guiding Care
    b. Determine the number of claims identified to review:

i. Review all claims if the number of claims is < 50.
ii. Determine the sample size needed if the claim volume is >50.

c. Determine if audited sample represents consistent or inconsistent behavior
    i. Inconsistent behavior will result in provider education and a second review in 90 days.
    ii. Consistent behavior will result in the completion of a Provider Intake Form.
        1. The Provider Intake Form (PIF) will be used to query other HPPF and NAFFA members to see if this provider has been identified as a potential FWA target.
        2. If the Plan receives credible information on the provider, a provider profile report will be completed, and the provider will be submitted to the SIU committee with the appropriate recommendations.
        3. If no credible information is received back on the provider, the provider will be placed on review consisting of education and monthly audits for 90 days.

Scheme Development:

FWA scheme development will be created and used via collaboration with the following organizations and health plan departments:

- Healthcare Fraud Prevention Partnership (HFPP or the Partnership)
- National Health Care Anti-Fraud Association (NHCAA)
- DHMP Compliance Department
- DHMP Legal Department

Technical Design

DHMP technology used to support and maintain its FWA processes will be developed and maintained by the plan's Information Systems department. The department is staffed with highly skilled software developers and data experts.

The primary source of data for associated schemes will be driven from claims, provider and member data from the DHMP enterprise data warehouse. A rules engine will be developed to support the identification of claims to be evaluated by the FWA team. A data model will be developed to maintain pertinent header level information and a monthly history for claims, provider and member data. Individual data models will be developed to support the presentation of data and the investigation for each scheme. The rules engine will drive how claims are identified for investigation to ensure the team is looking at the most recent claims by scheme and provide a history of claims identified for each scheme. Processing will be done monthly based on paid data from the previous month.

Presentation of the data will be driven by a custom developed Tableau dashboard to support each scheme. These dashboards will be developed in partnership the FWA team to ensure all requirements are met. The implementation process will be executed in an agile manner to implement the most critical schemes first and allow for continual delivery or new function along with maintenance fixes. Once implementation is complete, the IS team will work to develop ongoing releases to the application that include new features along with maintenance fixes.

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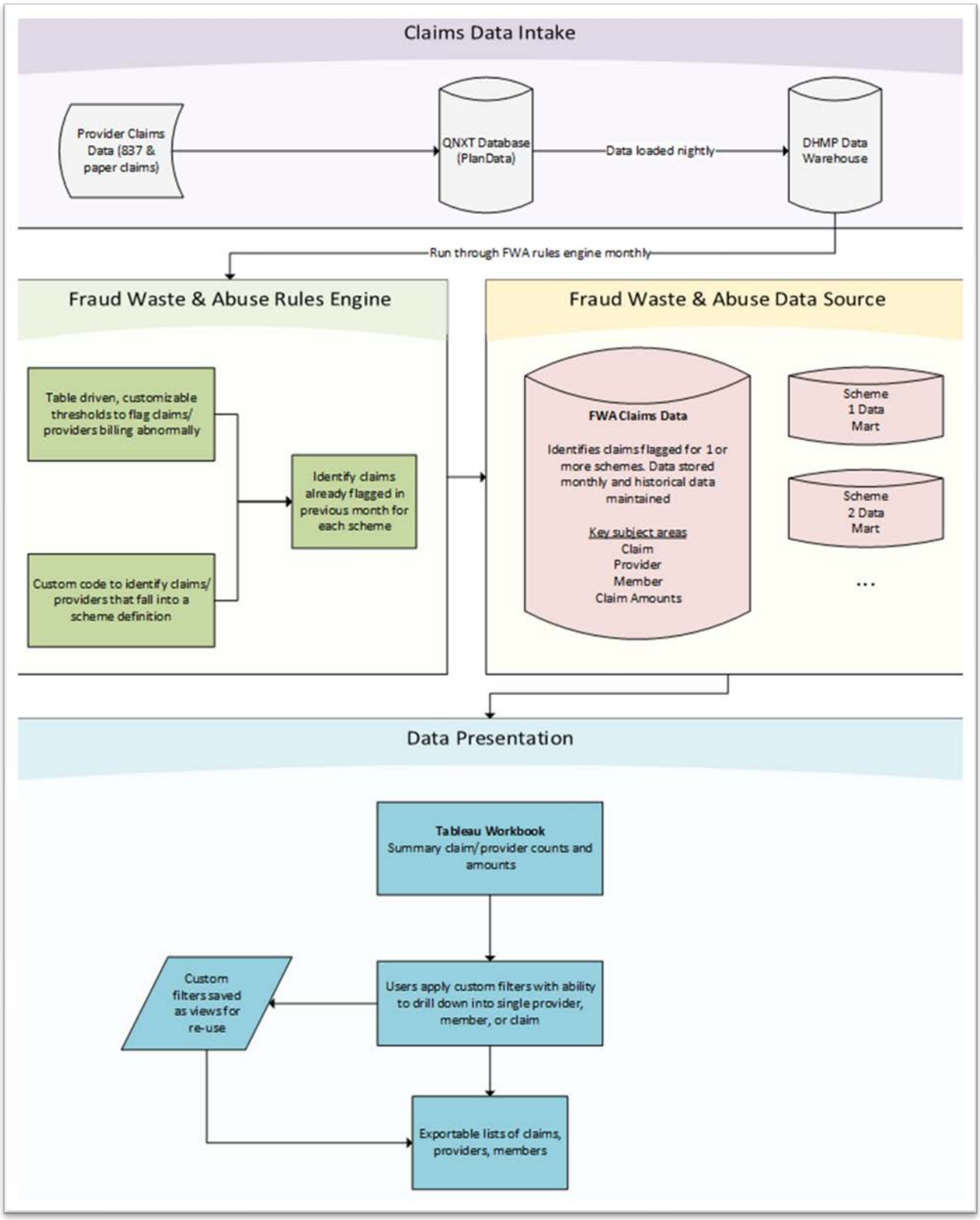

Systems:

- DHMP will use the following systems to perform FWA activities
    - QNXT Claims platform for:
        - Claims review
        - Case Initiation
        - Recovery
        - Reporting
    - DHMP Detect to identify claims meeting fraud scheme criteria
    - Plans Data Warehouse to retrieve claims data
    - Zelis- Plan claims auditing software
    - DMS (Document Management System) to house related documentation
    - Guiding Care - Letter generation

Reporting:

DHMP will utilize plan developed reports for reporting on the FWA program:

- Number of providers selected for review
- Number of providers referred to the SIU/Compliance by specialty
- Total number of claims and identified dollars for recovery
- Total number of members impacted by FWA
- Total number of providers terminated from network as a result of FWA
- Total number of providers on prep-pay status
- Total number of providers referred to regulatory agencies

Initial Scheme Description Library

- **Scheme 1** - Providers who consistently have claims denied or adjusted as a result of a coding review. Identification Process: Top 10 providers selected from Zelis editing report each Quarter

Target: This is an indication of potential incorrect or fraudulent billing where the provider is billing multiple codes to determine which codes have a higher reimbursement.

Process:

1. Determine % of claims billed incorrectly
2. Coding review report
3. Develop Provider profile
4. Present to SIU committee for further action
5. Provider education: 1 Discussion with Provider relations/Coding analysis
6. Provider education: 2 Discussion with Medical Director
7. Present noncompliance to SIU Committee
8. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 2** - Providers who submit an abnormally high number of corrected claims.

Identification Process: Providers are identified based on claims submitted within a quarter which are replaced with corrected claims.

Target: This is an indication of potential incorrect or fraudulent billing where the provider is billing codes to see which codes have a higher reimbursement.

Process:

1. Determine % of claims billed incorrectly
2. Coding review report
3. Develop Provider profile
4. Present to SIU committee for further action
5. Provider education 1: Discussion with Provider relations/Coding analysis
6. Provider education 2: Discussion with Medical Director
7. Present noncompliance to SIU
8. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 3** - Providers who submit claims that based on peer comparisons between patient volume for similar professional claims have abnormally high reimbursements or submit claims for unusually high numbers of procedures based on specialty and practice size.

Identification Process: Providers are identified and compared against their peers based on claims volume and services billed

Target: Outliers

Process:

1. Determine statistical sample to audit
2. Request medical records for review
3. Perform medical records /coding review
4. Develop Provider profile
5. Present results to SIU committee for further action
6. Provider education 1: Discussion with Provider relations/Coding analysis
7. Place provider on pre-pay review
8. Provider education 2: Discussion with Medical Director
9. Present noncompliance to SIU Committee
10. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 4** - A list of providers with a risk ranking of Low, Moderate or High based on high claim volume and reimbursement higher than the average of other providers in their peer group

Identification Process: Providers are ranked based predetermined thresholds set by the DHMP SIU Committee

Target: Outliers

Process:

1. Perform claims deep dive on statistical claim sample
2. Develop Provider profile
3. Present results to SIU committee for further action
4. Provider education 1: Discussion with Provider relations/Coding analysis
5. Place provider on pre-pay review
6. Provider education 2: Discussion with Medical Director
7. Present noncompliance to SIU Committee
8. Network termination/Referral to Regulatory or law enforcement body

Scheme Description

- **Scheme 5** - A list of providers who have never billed a lower level E&M code but have a higher E&M code in claim history.

Identification Process: members are identified based on claims history where a provider has not submitted a new patient E&M code but claims history shows payment for higher level E&M codes

Target: Detection of providers utilizing up-coding to receive a higher reimbursement when clinical documentation does support such

Process:

1. Determine statistical sample to audit
2. Request medical records for review
3. Perform medical records /coding review
4. Develop Provider profile
5. Present results to SIU committee for further action
6. Provider education 1: Discussion with Provider relations/Coding analysis
7. Place provider on pre-pay review
8. Provider education 2: Discussion with Medical Director
9. Present noncompliance to SIU Committee
10. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 6** - A list of Members receiving medications billed on both the medical and pharmacy side.

Identification Process: Medical and RX (Vendor) data is compared to determine duplicate or fraudulent billing

Target: Drug Diversion/Duplicate billing

Process:

1. Providers identified using MedIntegrate platform
2. Perform claims deep dive on statistical claim sample – Pharmacy Dept.
3. Develop Provider profile
4. Present results to SIU committee for further action
5. Provider education 1: Discussion with Provider relations/ Pharmacist
6. Place provider on pre-pay review
7. Provider education 2: Discussion with Medical Director
8. Present noncompliance to SIU
9. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 7**- A list of members receiving DME items that exceed the item's frequency limit.

Identification Process: DME Claims for members where the items frequency limit is exceeded

Target: Indication of fraudulent billing or diversion

Process:

1. Determine statistical sample to audit
2. Request medical records for review
3. Perform medical records /coding review
4. Develop Provider profile
5. Present results to SIU committee for further action
6. Provider education 1: Discussion with Provider relations/Coding analysis
7. Place provider on pre-pay review
8. Provider education 2: Discussion with Medical Director
9. Present noncompliance to SIU Committee
10. Network termination/Referral to Regulatory or law enforcement body

- **Scheme 8** - A list of hospitals who have submitted multiple inpatient claims that are not compliant with the 30 day-re admission requirements

Identification Process: Multiple claims for the same or similar DX that are submitted within the 30-day readmission window

Target: Fraudulent billing

Process:

1. Determine statistical sample to audit
2. Request medical records for review
3. Perform medical records /coding review
4. Develop Provider profile
5. Present results to SIU committee for further action
6. Provider education 1: Discussion with Provider relations/Coding analysis
7. Place provider on pre-pay review
8. Provider education 2: Discussion with Medical Director
9. Present noncompliance to SIU Committee
10. Network termination/Referral to Regulatory or law enforcement body