



CORPORATE POLICY

Subject: New Jersey Fraud, Waste and Abuse Prevention & Detection		
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:	Date Policy Last Revised:
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"/>
Check All That Apply: Policy is applicable to: Corporate <input type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): <u>New Jersey</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 New Jersey, Inc., its officers, Directors and associates obligations and efforts to detect, and prevent fraud, waste and abuse under the requirements of the New Jersey Medicaid Program.

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.

Health care claims fraud – means making, or causing to be made, a false fictitious, fraudulent or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services.

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.

Practitioner – means a person licensed in New Jersey to practice medicine and surgery, chiropractic, podiatric medicine, dentistry, optometry, psychology, pharmacy, nursing, physical therapy, or law; any other person

licensed, registered or certified by any State agency to practice a profession or occupation in the State of New Jersey or any person similarly licensed, registered or certified in another jurisdiction.

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

Policy

AMERIGROUP New Jersey, Inc. its 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.
- 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 (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 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.
 - 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;
- 6) The federal government may impose penalties of not less than \$5,500 and not more than \$11,000 plus 3 times the amount of damages sustained by the Government if there is a finding of a violation of the False Claims Act.
- 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 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) Medicaid fraud under New Jersey statutes is based upon the following actions
- a) Knowingly and willfully making or causing to be made any false statement or representation of material fact in any cost study, claim form, or any document necessary to apply for or receive any benefit

- or payment
- b) Knowingly and willfully making or causing to be made any false statement, written or oral, of a material fact for use in determining rights to such benefit or payment;
 - c) Concealing or failing to disclose the occurrence of an event which (i) affects the initial or continued right to any such benefit or payment or (ii) affects the initial or continued right to any such benefit or payment of any provider, person, firm, partnership, corporation or other entity in whose behalf he has applied for or is receiving such benefit or payment with an intent to fraudulently secure benefits or payments not authorized or in greater amount than authorized
 - d) Knowingly and willfully converting benefits or payments or any portion of the benefits or payments for the use and benefit of such provider or such person, firm, partnership, corporation or other entity to a use other than the use and benefit of such provider or such person, firm, partnership, corporation or entity
 - e) Any person found guilty of a high misdemeanor under this act will be subject to a fine of not more than \$10,000 and/or imprisonment of up to 3 years.
 - f) Any provider, or any person, firm, partnership, corporation or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with (1) furnishing of items or services for which payment is made or may be made in whole or in part under the medical assistance program or (2) the furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments if found guilty of a high misdemeanor will be liable for a penalty of up to \$10,000 and/or imprisonment of up to 3 years
 - g) Knowingly and willfully making or causing to be made or inducing or seeking to induce the making of any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify either upon initial or recertification as a hospital, skilled nursing facility, intermediate care facility or health agency, thereby entitling them to receive payments under medical assistance will result in conviction of a high misdemeanor and a penalty of not more than \$3,000 and/or imprisonment of not more than 1 year.
 - h) A violation of any of the items listed above may also result in civil penalties including payment of interest on the amount of the excess benefits or payments, payment of an amount not to exceed three times the amount of the excess payment or benefit and payment in the sum of \$2,000 for each excessive claim for assistance, benefits or payments.
 - i) A violation may also subject the individual person or entity to suspension, debarment, or disqualification from the medical assistance program.
 - j) A practitioner and or a non-practitioner convicted of health care claims fraud may be subject to a fine of up to 5 times the monetary benefit obtained or sought to be obtained.

11) Insurance Fraud under New Jersey statute

- a) A person is guilty of insurance fraud if that person knowingly makes, or causes to be made a false, fictitious, fraudulent, or misleading statement of material fact in or omits a material fact from, or causes a material fact to be omitted from any record, bill, claim or other document, in writing, electronically, orally or in any other form, that a person attempts to submit, submits, causes to be submitted or attempts to cause to be submitted as part of, in support of, or opposition to or in connection with (1) a claim for payment, reimbursement or other benefit pursuant to an insurance policy, or form an insurance company (2) an application to obtain or renew an insurance policy (3) any payment made or to be made in accordance with the terms of an insurance policy or premium finance transaction or (4) an affidavit, certification, record or other document used in any insurance or premium finance transaction .
- b) Insurance fraud constitutes a crime of the second degree if the person knowingly commits five or more acts of insurance fraud, including acts of health care claims fraud and if the aggregate value of the property, services or other benefit wrongfully obtained or sought is at least \$1,000.
- c) The Insurance Fraud Detection Reward Program includes a 24 hour toll free insurance fraud hotline designed to receive information from members of the public who have knowledge of or who believe that an act of health care claims fraud, insurance fraud or any other criminal offense involving or related to an insurance transaction is being or has been committed. The Attorney General is authorized to pay a financial reward for the receipt of information leading to the arrest, prosecution and conviction of persons under this program.
- d) Anyone making a good faith report will have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as a result of the act.

12) 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.

13) Nonretaliation. Protections against retaliation exist under AMERIGROUP policies 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. New Jersey statute also protects employees from retaliation for reporting a violation of state or federal rules, or regulations, or the misuse of public resources, participating in an investigation, hearing or inquiry into any violation and/or objecting to participate in any violation of law or regulation.

Exceptions	None
References	31 USC 3729 et al, 31 USC 3801 et al, NJS 30:4D-17(a)-(d), NJS 30:4D-7.h., NJS. 30:4D-17(e)-(i), NJS 30:4D-17.1.a, NJS 2C:21-4.2 and 4.3, NJS 2C:51-5 and NJS 34:19-1 et seq.
Related Policies and Procedures	Compliance Reporting; Code of Business Conduct & Ethics; Fraud Waste and Abuse Prevention & Detection
Related Materials	N/A