

**Beacon Comprehensive Behavioral Health Management
Policy and Procedure Manual**

Policy Name: Claims Fraud	Claims
Date: 11-08	Page: 1 of 2
Reviewed by QI Committee: 11-08, 7-09, 7-10, 7-11	Policy Number: CL-3
Revised by QI Committee: 7-09, 7-11	

Purpose: To ensure that Beacon Comprehensive Behavioral Health Management (Beacon CBHM) adheres to all state and federal regulations concerning claim submission and payment and that Beacon CBHM, providers, and members are protected from fraudulent billing practices.

Policy:

1.0 Prevention

- 1.1 IT Access Rights – Beacon CBHM establishes access rights for each employee based upon their job function. Reference SC-4, “*Scope of Access*”
 - 1.1.1 Employees who create provider payment authorizations are not able to create provider files or post a provider claim for payment.
 - 1.1.2 Employees who create provider files are not able to post a provider claim for payment.
 - 1.1.3 Employees who post provider claims for payment are not able to create a provider file or a provider authorization for payment.
- 1.2 Tax ID Review – All claims are posted against provider authorizations. The provider authorization references the provider’s Tax ID on file. This Tax ID must match the Tax ID submitted on the claim.
- 1.3 Check Review
 - 1.3.1 The Vice-President of Financial Operations and the President review all checks over \$5,000 prior to mailing.
 - 1.3.2 The Vice-President of Financial Operations reviews all non-MD checks over \$1,000 prior to mailing.
 - 1.3.3 The Manager of Network Management reviews the check register for any provider name not recognizable.
- 1.4 Audits
 - 1.4.1 The Claims Manager and/or the Claims Team Lead conduct random processor claims audits daily.
 - 1.4.2 The Financial Auditor for Beacon CBHM conducts random claims audits during the annual audit.

2.0 Identification

- 2.1 Whenever a potential claims fraud is identified it should be reported to the Claims Investigation Team. The Claims Manager, Vice-President of Financial Operations or the Vice-President of Product Management and Compliance are also notified.
- 2.2 Identification can occur as a result of
 - 2.2.1 Prevention activities noted in Section 1.0
 - 2.2.2 Investigation of a patient complaint
 - 2.2.3 Investigation of a provider complaint
 - 2.2.4 Medical record audit

**Beacon Comprehensive Behavioral Health Management
Policy and Procedure Manual**

Policy Name: Claims Fraud	Claims
Date: 11-08	Page: 2 of 2
Reviewed by QI Committee: 11-08, 7-09, 7-10, 7-11	Policy Number: CL-3
Revised by QI Committee: 7-09, 7-11	

- 2.2.5 Employee performance evaluation
- 2.3 When potential claims fraud is identified, the Claims Investigation Team completes the Claims Fraud Investigation Report.

3.0 Investigation

- 3.1 The Claims Investigation Team initiates an investigation.
- 3.2 The investigation may include one or more of the following activities
 - 3.2.1 Phone conversation with member
 - 3.2.2 Phone conversation with provider
 - 3.2.3 Review of provider medical records
 - 3.2.4 Review of submitted claim forms
 - 3.2.5 Review of ledger history
- 3.3 Investigation activities may be assigned to other Senior Management staff as needed.
- 3.4 All notes regarding the investigation are entered into the electronic record either as provider notes or member notes, when a complaint is member specific.
- 3.5 After completing their investigation, the Claims Investigation Team forwards their findings report to the Vice-President of Product Management and Compliance or Vice-President of Financial Operations for final review and appropriate response.

4.0 Response

- 4.1 If the investigation concludes that there was no intentional claims fraud, the actions taken may include one or more of the following:
 - 4.1.1 Member education
 - 4.1.2 Provider education
 - 4.1.3 Claims refund request
 - 4.1.4 Provider placed on probation with corrective action required
 - 4.1.5 Notification to payer
- 4.2 If the investigation concludes that there was intentional claims fraud, the actions taken will include:
 - 4.2.1 Claims refund request
 - 4.2.2 Termination of CHIPA provider agreement
 - 4.2.3 Notification to payer

5.0 Reporting

- 5.1 All Claims Fraud Investigations will be reported to the QI Committee. The QI Committee will trend and track to determine if operational changes are required.