I. POLICY

It is the policy of Community Care to have a fraud, waste and abuse (FWA) compliance program which reflect the regulations, recommendations, standards and guidance set forth by the following agencies towards the detection, deterrence and prevention of FWA in Medicaid-funded HealthChoices behavioral healthcare:

- US Justice Department
- Office of Inspector General (OIG)
- Attorney General’s Medicaid Fraud Control Section (MFCS)
- Medical Assistance/Medicaid program
- Bureau of Program Integrity (BPI)
- Office of Mental Health and Substance Abuse Services (OMHSAS) of the Department of Human Services (DHS)
- Centers for Medicare and Medicaid Services (CMS)

Specific tools and references used by the FWA program include but are not limited to: Medical Assistance Regulations and Bulletins, the Pennsylvania Code and licensing regulations, DHS HealthChoices Behavioral Health Program Standards and Requirements: Appendix F Fraud and Abuse Program Requirements (DHS Appendix F), fee schedules, Billing Manual, Provider Alerts as well as the Community Care Provider Contract itself.

The FWA compliance program structure is designed to support monitoring and intervention with Community Care network Providers through the implementation of various tools, strategies and procedural controls. These include:

- Communication and collaboration with Primary Contract Administrators
- Development of a FWA Special Investigations Unit (SIU), appointed Director and staff
- Claims monitoring

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**Fraud, Waste and Abuse (FWA) Compliance Program**

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- Billing compliance audits
- Establishment of Provider requirements in response to audit findings
- Support to Providers for self-reporting
- Monitoring for excluded or sanctioned Providers
- Member verification of services
- Reporting and referral
- Cooperation with regulatory and law enforcement agencies
- Information, education and resource provision
- Requiring Providers to maintain and produce to Community Care their compliance plans which are to include FWA training

**II. DEFINITIONS**

The terms, “Fraud”, “Waste” and “Abuse” and examples of FWA below are derived from the DHS Appendix F as follows:

- **Fraud** – Per §42 CFR Part 455.2 – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

  This includes any intentional deception or misrepresentation made by an entity or person in a capitated Managed Care Organization (MCO) or other managed care setting with the knowledge that the deception could result in an unauthorized benefit to the entity, him/herself or another responsible person in a managed care setting.

- **Waste** – (as defined by CMS for Medicare Part D) – Overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.
• Abuse – Per §42 CFR Part 455.2, Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

This includes practices in a capitated MCO defined above as abuse or that fail to meet professionally recognized standards or contractual obligations (including the terms of the Program Standards and Requirements, contracts, and requirements of state or federal regulations) for health care in the managed care setting. This may be committed by an MCO, Contractor, Subcontractor, Provider, State employee, Medical Assistance (MA) beneficiary or MA managed care enrollee, among others.

While it is not the primary focus of the FWA program to assign a category to a deficient audit finding as “fraud”, “waste” or “abuse”, an important defining characteristic that discriminates fraud from waste or abuse is “intentional deception” that does or could result in a gain to the Individual, Provider or other entity. Any deficient audit finding regardless of type (fraud, waste, abuse) results in remediation by the FWA program.

Examples of suspected Fraud, Waste or Abuse. (Some examples include the intent to deceive for an unauthorized benefit [fraud], while others do not [waste, abuse]):

• Billing for services or supplies not rendered
• Falsifying or altering claims, encounters or record documentation
• Billing a higher code than services performed – incorrect coding
• Double billing or unbundling billing for services
• Failing to maintain appropriate records - Record keeping issues
• Duplication of medications or services
• Any issue that could result in collection of overpayment

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Fraud, Waste and Abuse (FWA) Compliance Program

PURPOSE

The purpose of this policy is to describe the FWA program.

SCOPE

This policy applies to all Community Care departments and to the Provider Network.

PROCEDURE

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Examples of FRAUD (intent to deceive for an unauthorized benefit) include:

- Prescription alteration or forgery
- Inappropriate use of a member’s card
- Suspected member fraud or abuse
- Frequent emergency room, physician, pharmacy or hospital visits
- Employee or subcontractor theft or embezzlement
- Discrimination or abuse (physical, mental, sexual) of a member

Examples of FRAUD (intent to deceive for an unauthorized benefit) include:

- Billing for a time period greater than the time actually spent with the client
- Billing for the provision of a service that did not meet the service definitions, performance specifications, state or federal regulations, or accreditation standards customarily recognized in behavioral health care
- Inappropriate or frequent referrals that may constitute a conflict of interest
- Authorizations for services to Providers who may have personal or financial relationships with care managers or other staff members
- Other related claims or care management issues that may involve intentional deception or misrepresentation as referenced above
A. Claims Monitoring

1. The SIU and/or other Community Care departments (such as Quality, Clinical and Network Provider Relations) scan various sources of information and analyze claims to detect potential FWA. Sources of information and processes may include:
   a. Referrals to the SIU
   b. Hotline reports
   c. Member complaints and grievances
   d. Post processing review of claims
   e. Claims edits and edit testing to prevent duplicate or unauthorized payment
   f. Prepayment claims holds and auditing
   g. Routine and random chart audits
   h. Communication with and referrals from the Contract Administrators and Community Care’s Regional Directors, Care Management, Provider Reimbursement, Network, Clinical and Quality Management Departments, etc.
   i. Data mining queries (unusual claims, coding and utilization patterns)
   j. Provider self-reports
   k. Cooperation/collaboration with external regulatory and law enforcement agencies

B. Self-Reporting

1. Providers are encouraged to utilize the option of self-reporting FWA concerns to the Community Care SIU when the individual/agency identifies an issue internally. The SIU will work with the Provider to validate their findings and process repayment, when indicated.
2. Alternately, Providers may use the PA Medical Assistance Provider Self-Audit Protocol to voluntarily disclose overpayments or improper payments of MA Funds directly to the DHS. The protocol is available on the DHS website under “Fraud and Abuse” or a Provider may contact Community Care’s SIU through the FWA hotline for assistance at 1-866-445-5190.

C. Provider Requirements in Response to Audit Results

1. The findings of FWA audits conducted by the SIU may indicate the need for:
   a. Provider information, education or resource provision
   b. Payment recovery
   c. Reporting or referral to aforementioned external agencies (typically, the BPI) and/or Community Care Departments, etc.
   d. Corrective Action Plan (CAP)
   e. Re-audit

2. When repayment is required, the Provider will receive written notification of the FWA audit exceptions (deficiencies) and amount of repayment due to Community Care. Repayment is generally accomplished through retraction of current or future claims submitted to Community Care by the Provider. Alternately, with prior consent of the Primary Contract Administrator, Community Care may honor the request of a Provider to establish a payment plan to Community Care in lieu of claims retraction.

D. Exclusion from Participation in the Medical Assistance Program

1. Community Care’s contracting/credentialing/re-credentialing and FWA programs monitor Provider compliance with MA Bulletin 99-11-05 “Provider Screening of
Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation”.

2. MA Bulletin 99-11-05 requires Providers to:
   a. Establish upon hire and through monthly screening that their employees and contractors, both individuals and entities, have not been excluded from participation in Medicare, Medicaid or any other federal health care program.
   b. Recognize consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals or entities.
   c. Conduct self-audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor to Community Care’s Network Management and the BPI.

3. Community Care will immediately initiate the termination of a Provider from participation in the network upon notification from the DHS that the Provider is suspended or terminated (precluded or debarred) from participation in the Medicaid or Medicare Programs.

4. Monthly, the UPMC Office of Ethics and Compliance communicates and collaborates with the SIU to verify that Providers sanctioned by the state or federal government (from participation in the Medicaid program) or who are excluded from receiving federal financial and non-financial assistance and benefits are not participating in the Community Care network through the following sources:
   a. State Department’s Medicheck List
   b. Federal Office of Inspector General’s List of Excluded Individuals and Entities (LEIE)
Fraud, Waste and Abuse (FWA) Compliance Program

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E. Verification of Services and Encounter Forms

1. The SIU engages in written and telephonic verification of services directly with members. The purpose of this communication is to validate with the member that they have received the services billed to the Medical Assistance/Medicaid program as Medicaid members do not receive an explanation of benefits/services received.
2. Another method of service verification utilized by the SIU is to routinely audit for the presence and completeness of member Encounter Forms. Providers must obtain accurate, complete and truthful Encounter Form documentation for each and every service delivered according to Medical Assistance Bulletin 99-89-05 and 99-03-21. All independent and facility-based (including community-based) services are required to maintain Encounter Forms with the exception of inpatient hospital and a few other services identified in the bulletins.

F. FWA Compliance Auditing

1. Audit selection is based on the annual Contract Work Plan, regulatory guidance, program standards and referrals.

2. Audit sample size is variable and consistent with parameters recommended by the DHS relative to the audit type, level of service and audit time frame.

3. Extrapolation of audit results may be applied to a larger group of claims under certain situations.

4. Verification of services with members may be conducted during the audit.

5. Unannounced audits may be conducted based on issues identified in a complaint, referral, or data mining reports, queries or other sources.

6. The steps in the routine audit process include:
   a. Audit notification and schedule
   b. Member record request
   c. FWA onsite or desk audit

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d. Exit interview: audit findings, requirements, appeal process, clarification to Provider inquiries, reference to Community Care resources, regulations and educational materials. Contract Administrators are invited to participate.

e. Formal communication of audit results to the Provider, including appeal option.

For detailed information related to the FWA audit and appeal process, see policies: Fraud, Waste and Abuse Compliance Auditing (FWA003) and Fraud, Waste and Abuse Audit Appeal (FWA011).

G. Provider Compliance Plans

1. Providers are required to prepare, maintain, and implement written Compliance Plans and procedures as condition to entering into a Provider Agreement with Community Care.

2. These Plans must include Compliance Plan elements as described in Community Care’s Provider Alerts and Manuals and the DHS Appendix F.

3. Plans must also include regularly scheduled FWA training programs, addressing applicable federal and Commonwealth fraud and abuse laws and regulations.

4. The Provider is responsible to measure or track the sufficiency and adherence to their Compliance Plans in meeting the requirements of applicable laws and regulations and including the DHS Appendix F.

5. The Provider must submit to Community Care’s Network Provider Relations a copy of their Compliance Plan at the following intervals:

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a. Initial credentialing (affirming Plans prior to effective date of a Provider Agreement)
b. Re-credentialing
c. When any revisions, updates, or modifications are made and adopted to the plan.
d. During any on-site Provider audits and site visits.

6. At the aforementioned intervals, Network Provider Relations will validate inclusion of the FWA training requirement within the Provider’s Plan.

7. Upon request, Network Provider Relations will provide the Contract Administrator with a copy of a Provider’s Compliance Plan and supporting information evidencing FWA training.

8. Annually, in the first calendar quarter, Community Care will submit a request to each Provider for both verification of FWA training completion for the preceding calendar year (for Providers who have been under contract with Community Care for the full preceding year) as well as a schedule for FWA training for the upcoming year (all enrolled Providers).

9. After the close of the first calendar quarter, Community Care shall submit to each Contract Administrator, a report which summarizes Provider FWA training completion and schedule for their respective contract.

REPORTING, REFERRAL DISPOSITION and COMMUNICATION

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A. Reporting

1. The FWA SIU accepts referrals from external (Primary Contracts, BPI, regulatory and law enforcement agents, hotline, members, Provider staff, etc.) and internal sources. The FWA Director is available to assist stakeholders in determining potential referrals to the SIU. For detailed information on reporting fraud, waste and abuse, regulatory basis, applicable law, regulation and whistleblower protections, please see policy: False Claims Act (FWA010).

2. All issues related to suspected fraud, waste and abuse should be reported to the FWA SIU utilizing the **FWA Hotline, 866-445-5190**, the **FWA e-mail at CCBH_Fraud_Abuse@ccbh.com** or may be made in writing and forwarded to the Community Care Behavioral Health, Director of Fraud, Waste and Abuse, 600 Grant Street, 5th Floor, Pittsburgh, PA 15219.

3. Community Care staff members and departments receive training on the identification of and immediate reporting of FWA concerns to the SIU and the Contract Administrator, as necessary.

B. Referral Disposition

1. The disposition of a FWA referral is dependent on the nature of the concern:
   a. No action if no FWA issue is identified or the report requires no follow up or referral.
   b. Referral to the appropriate Community Care department if the report involves issues which do not appear to involve suspected fraud, waste or abuse, but may relate to clinical, quality, care management or contractual matters.
   c. Examination of claims, authorizations or data analysis to determine if an audit is indicated.
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<td>d.</td>
<td>Conduct an audit to determine if there is any evidence of activity suggestive of a pattern of fraud, waste, or abuse.</td>
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<td>e.</td>
<td>Conduct an expedited, preliminary review, usually on-site, if the report appears egregious.</td>
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<td>f.</td>
<td>Open an investigation file for each involved Contract.</td>
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### C. Collaboration with Primary Contract Administrators

1. Community Care engages in collaborative working relationships with and on behalf of our Contract Administrators. Contract Administrators are informed of the various stages of the process related to FWA matters as identified in the DHS Appendix F. This includes information sharing and periodic updates that may arise related to legal matters. All parties maintain confidentiality with respect to FWA matters.

2. Conflict of interest is avoided with UPMC-affiliated providers through FWA processes as evidenced by:
   a. Corporate Compliance Plan, Structure, Policy & Procedure (Conflict of Interest – General Obligations, UPMC HealthSystem Policy HSEC-1700) which includes a Compliance Helpline and Whistleblower protection communication
   b. Staff wide education and publically posted information on the availability of anonymous FWA reporting
   c. Blanket data mining queries across all submitted claims regardless of Provider
   d. Transparent audit activity reporting to the Primary Contract Administrators
   e. Co-development of annual and revised audit work plans with the Contract Administrators
   f. Elective participation by Contract Administrators in the Audit process

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g. Participation of the Contract Administrators as voting members of the Appeal Committee
h. Copying the Contract Administrators on all correspondence
i. Reports identifying provider, type, level of care and other variables which drive audit selection
j. Consulting with the Contract Administrators prior to approval of payment plans or potentially permissible arbitration (nominal nature)
k. Participation in routine and off-year external auditing processes

3. Whether received directly by the SIU through a hotline or referral from the Contract Administrator, the Director of FWA and the Regional Director will maintain communication relative to potential FWA issues and referrals. The Contract Administrators will receive immediate notification for significant allegations. Routine referrals, once opened, will be reported to Contract Administrators on a weekly basis.

4. The Regional Director (or designee) as the primary contact for the Contract Administrators, will review and submit referrals to FWA on behalf of the Contract. Contract Administrators, or their designees, also submit referrals to the Director of FWA, directly.

5. The Director of FWA and the Regional Director will assure that Contract Administrators receive routine and timely communication relative to FWA issues. This includes weekly updates, inclusion on routine steps of the FWA process (correspondence), routine reports (weekly, monthly, quarterly, and annually) and ad hoc communications that reflect the activity of the SIU.

D. Reporting Suspected Fraud, Waste and Abuse to the BPI

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1. The FWA Director, or designee, will complete and submit the “MCO Referral Form” with supporting documentation to the BPI under the following circumstances and within 30 business days of identifying the concern:
   a. Potential violation the Federal False Claims Act
   b. Falsifying claims/encounters
   c. High dollar financial impact
   d. Provider self-reports
   e. Audits requiring Corrective Action Plan
   f. Abuse of recipient
   g. Denial of service (access, necessary referrals, specialist referrals, underutilization)
   h. Identified on LEIE, PA Medicheck, SAMS, or other state or federal data base
   i. Loss of license/expired license
   j. Provider, subcontractor or employees who are suspended, resign, or voluntarily withdraw after initiation of a FWA audit
   k. Controlled substance issue
   l. Criminal conviction
   m. Notification/request from the BPI
   n. Potential systemic or operational issues in one of the following areas: balance billing, billing or payment error, duplicate billing, unbundling codes, upcoding, inappropriate modifier use, medical necessity, services not rendered, missing/insufficient documentation
   o. Inconclusive, inadequate or suspicious audit findings or other discretionary reasons, including situations which may lead to a determination of a credible allegation of fraud

2. Each Contract affected by the concern will be informed of any reports to the BPI through the Director of FWA and/or Regional Director, or designees, on the same day that the referral is submitted to the BPI.

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E. Quarterly Reporting to the BPI

1. The FWA SIU Director submits the “MCO Quarterly Compliance Report” as required to the BPI and the Contract Administrator. The report identifies detection and sanctioning activity including: SIU cases under review, exceptions identified, approximate recovery dollar amounts, Providers terminated due to Medicare/Medicaid preclusion and overpayment, etc.

2. BPI reporting requirements are defined online at:

3. A certification statement signed by the Chief Executive Officer, the Chief Financial Officer or the Chief Operations Officer and the SIU Director and/or Compliance Officer accompanies each quarterly submission. A new statement is submitted with any report edits.

F. Duty to Cooperate with Oversight Agencies

Community Care fully cooperates with state and federal agencies that conduct detection and prosecution activities. These agencies include, but are not limited to the: BPI, Office of the Budget, MFCS, PA and Federal OIG, and the United States Justice Department. Cooperation includes:

- Providing access to case information, computer files, and appropriate staff
- Complying with the imposition of payment suspension to a Provider at the request of the DHS and the MFCS (including those matters related to a credible allegation of fraud)
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- Participating in periodic FWA training sessions, meetings, and joint reviews of Providers or members

## INFORMATION, EDUCATION and RESOURCES

### A. Community Care Staff Training

1. Community Care staff receive training on compliance, FWA identification and reporting, confidentiality, organizational policy and procedure as well as regulations and standards relative to Behavioral Health MCO operational functions. Training occurs on hire, annually and periodically.

2. The FWA Director, Sr. Directors of Network Relations, Quality and Clinical and the Regional Directors will develop an annual training schedule to assure that staff reporting to the aforementioned areas:
   a. complete initial and ongoing education on FWA recognition and reporting,
   b. utilize the process and procedure to identify and report potential FWA cases to the SIU and to the Contract Administrator, as applicable, and
   c. maintain awareness of the availability of consultation with the FWA Director

### B. FWA Provider Education and Resources

1. All newly enrolled Providers receive mandatory training related to the state, federal and Community Care FWA program requirements, regulations, policies and procedures.

2. Providers are required to establish FWA education and information sharing within their organizations and include this within their Compliance Plan.

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3. The following resources are beneficial and in many cases required for the Provider of which to maintain awareness in order to demonstrate expected fraud, waste and abuse prevention and compliance within their agencies. These resources reflect both programmatic (clinical/service) material as well Medical Assistance billing and claims submission requirements:
   a. Community Care - Provider Agreement (Contract)
   b. Community Care Website: www.ccbh.com
      i. Provider Newsletters, Manuals and Alerts
      ii. FAQs
      iii. Fraud, Waste Abuse Policies & Procedures
   iv. Fraud, Waste Abuse Provider Training (state, federal, and Community Care - FWA regulations, requirements, resources)
   c. Regulatory References:
      i. DHS HealthChoices Behavioral Health Program Standards and Requirements (Including: Appendix F Fraud and Abuse Program Requirements)
      ii. State, federal program and billing regulations, requirements and bulletins, applicable to each service offered by the Provider
      iii. Title 55 Chapter 1101. 51 (d) and (e), Medical assistance Bulletin 29-02-03, “Documentation and Medical Record Keeping Requirements”, et seq.
      iv. MA Bulletin 99-11-05 (Subject: Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation)
   v. Community Care’s documentation requirements outlined in the Performance Standards, provider fee schedule and other applicable federal and state law and regulation regarding documentation for specific Provider services
   vi. Program Integrity: Documentation Matters Toolkit. Medicaid medical records documentation matters!

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POLICY AND PROCEDURE MANUAL

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vii. Medicaid Documentation for Behavioral Health Providers
www.cms.gov/Medicare-Medicaid-Coordination/...

viii. Program Integrity: Self-Audit Toolkit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html

4. FWA education for Providers and the Contract Administrators include the development of training, local and webcast events and FAQs. Basic FWA information, the auditing process, trends and specific audit exception trends are discussed. The focus of the program is to assist Providers in maximizing compliance with billing and programmatic compliance relative to fraud, waste abuse prevention, detection and deterrence. Onsite training will be available to each Contract Administrator annually as requested.

5. Community Care periodically notifies Providers via Provider Alert or other method as to the availability of and updates to training materials and other resources on the website.

6. Members and Providers are encouraged to report FWA and Providers may seek consultation regarding suspected fraud, waste or abuse through:

Community Care’s toll free FWA Hotline number: 1-866-445-5190
Or via email at: CCBH_Fraud_Abuse@ccbh.com

7. DHS offers a toll-free Fraud and Abuse hotline and an explanatory statement intended for distribution to Members and Providers. Providers should review the information appended this policy and include the member level information in their handbooks (at the time of next reprint). See Appendix A.
APPENDIX: A

DHS Toll-Free Fraud & Abuse Hotline - Information for Inclusion in Provider Handbooks:
The Department of Human Services has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DPW-TIPS (1-866-379-8477) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Some common examples of fraud and abuse are:
Billing or charging Medical Assistance recipients for covered services
Billing more than once for the same service
Dispensing generic drugs and billing for brand name drugs
Falsifying records
Performing inappropriate or unnecessary services

Suspected fraud and abuse may also be reported via the website at:
http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresp

All policies, procedures, standards, directives, rules or regulations contained in these materials and however denominated, developed, published, or promulgated by Community Care Behavioral Health are subject to change, revision, modification or withdrawal by Community Care Behavioral Health at any time without notice and subject only to any required governmental approvals or contractual obligations as to such changes or modifications.

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DHS Toll-Free Fraud & Abuse Hotline - Information for Inclusion in Member Manuals:

**DHS Fraud and Abuse Hotline:**
The Department of Human Services has a hotline if you want to report a medical provider (for example a doctor, dentist, therapist, hospital) or business (medical supplier) for suspected fraud or abuse for services provided to anyone with an ACCESS card). The hotline number is 1-866-DPW-TIPS (1-866-379-8477).

Some common examples of **fraud and abuse** are:
- Billing or charging you for services your health plan covers
- Offering you gifts or money to receive treatment or services
- Offering you free services, equipment, or supplies in exchange for your ACCESS number
- Giving you treatment or services that you don’t need
- Physical, mental, or sexual abuse by medical staff

You can call the Hotline and speak to someone Monday through Friday, 8:30AM to 3:30PM.

You may leave a voice mail message at other times. If you don’t speak English an interpreter will be made available. If you are hearing impaired you can call the hotline using your TTY device.

You do not have to give your name and if you do, the provider will not be told you called.

You can also report suspected fraud and abuse by using the website: [http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/maprovidercompliancehotlinerespons](http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/maprovidercompliancehotlinerespons). This has been set up so you do not have to give your name also.

**Records Retention**

All policies, procedures, standards, directives, rules or regulations contained in these materials and however denominated, developed, published, or promulgated by Community Care Behavioral Health are subject to change, revision, modification or withdrawal by Community Care Behavioral Health at any time without notice and subject only to any required governmental approvals or contractual obligations as to such changes or modifications.
Community Care business units are responsible for verifying that records are retained according to established internal processes.

Unless otherwise mandated by Federal or State law, or unless required to be maintained for litigation purposes, any documents, regardless of medium, recorded pursuant to this Policy are maintained for a minimum of ten (10) years from the date of recording.