BULLETIN
OMC2000-002

TO: **ALL HEALTH MAINTENANCE ORGANIZATIONS**

FROM: **MARILYN DAHL, SENIOR ASSISTANT COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES**

DATE: **JULY 20, 2000**

RE: **FRAUD INVESTIGATIONS AND TERMINATION OF HEALTH CARE PROFESSIONALS**

In accordance with the provisions of the Health Care Quality Act, P.L. 1997, c. 192 (as generally codified, N.J.S.A. 26:2S-1 et seq.) health maintenance organizations (HMOs) and other carriers offering managed care plans, as defined by the act and rules promulgated pursuant thereto, may terminate a health care professional on the basis of fraud without affording that health care professional either 90-days prior notice of termination, or an opportunity for a hearing as otherwise prescribed by the statutes at N.J.S.A. 26:2S-8. However, the Department of Health and Senior Services (Department) anticipates that both HMOs and other carriers will have in place standards for the investigation of suspected fraudulent activity by health care professionals, including notice to the professionals concerned; and that neither HMOs nor other carriers will terminate a health care professional on a mere allegation of fraud by an individual or another organization, or a suspicion of fraud raised internally, without engaging in an investigation to substantiate, if not prove, the veracity of the allegations, except as set forth in this bulletin.[1]

Specifically, the Department believes that HMOs should have in place written policies and procedures for the detection and investigation of suspected fraud by health care providers. These policies and procedures should include:

- the indicators against which all health care providers, including health care professionals, will be measured to determine whether the HMO will pursue an investigation;

- the personnel within the HMO that are authorized to carry out an investigation, or the types of vendors to which the HMO may refer an investigation (in no instance should the

[1] The Department is aware that essentially all carriers that offer private passenger auto or health insurance in New Jersey, other than HMOs, must file a fraud detection plan with the Department of Banking and Insurance, and generally have in place a Special Investigation Unit, which meets certain standards, including establishing the indicators of fraud that the carrier will consider in determining to pursue an investigation, standards for training of investigators, standards for the actual investigation and verification of evidence, and standards for determining when to send the information to the State's Office of the Insurance Fraud Prosecutor. Carriers subject to the Fraud Prevention Act (N.J.S.A. 17:33A-1 et seq.) and rules promulgated pursuant thereto (including N.J.A.C. 11:16), are not required to meet any additional standards with respect to their participating health care professionals.

person performing the investigation be within the claims processing or underwriting functions of an HMO[2]);

- specifications for the education and training that those persons performing an investigation must have in order to perform an investigation;

- specifications of the standards of evidence on which an HMO will base a determination of reasonable suspicion of fraud;

- the process to be used to give notice of findings to the provider and the opportunity for the provider to respond, prior to making a determination.

The written policies and procedures of the HMO should be disseminated or otherwise made available to all investigators, claims adjusters and underwriting personnel, if any.

Personnel, education and training

HMOs may establish their own standards for appropriate numbers of personnel dedicated to fraud detection and investigation, as well as the education and training of those personnel. However, because HMOs are required to report fraud or suspected fraud to the Division of Criminal Justice within the New Jersey Department of Law and Public Safety, HMOs should establish standards that are consistent with those applicable to other carriers subject to the Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq. Rules addressing those standards have been promulgated jointly by the Department of Banking and Insurance and the Office of the Insurance Fraud Prosecutor at N.J.A.C. 11:16.

Investigation and evidence with respect to claims (N.J.S.A. 17:33A-1 et seq.)

When an HMO believes the facts and circumstances of a situation create a reasonable suspicion that a health care provider has acted fraudulently by violating N.J.S.A. 17:33A-4, the HMO must report the suspected fraud to the OIFP using the appropriate referral form for such reports (currently, Notification Form OIFP-2). Suspicion of fraud may be based on the HMO's fraud indicators included in the HMO's written policies and procedures, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of N.J.S.A. 17:33A-4 has occurred.

When there is sufficient independent evidence corroborating the reasonable suspicion of fraud, the HMO must report the suspected fraud to the OIFP using the appropriate referral form (currently, Referral Form OIFP-1A), regarding violations of N.J.S.A. 17:33A-4. Independent corroborating evidence should include, but not be limited to: (a) statements from a witness; (b) documentary evidence directly negating, or otherwise establishing the falsity of a claim; (c) a report of an expert; or (d) additional misrepresentations by the health care provider that tend to negate the possibility that prior misrepresentations were mere error.

The HMO may deem its investigation of the matter complete for purposes of referral to OIFP, and for purposes of taking other action that the HMO may wish to pursue regarding the

[2] Separating investigators from the claims processing functions should not prohibit the investigator from authorizing the payment of a pended claim following an investigation, if payment is appropriate.

matter, including termination of the provider from the HMO network, when reasonable and appropriate investigative leads and opportunities have been exhausted. When an investigation identifies a pattern of possible violations of N.J.S.A. 17:33A-4, the HMO's investigation may be deemed complete when at least one of the violations included in the identified pattern have been sufficiently investigated and corroborated.

Investigation and evidence with respect to other possible fraudulent activity

When an HMO suspects that a participating health care provider, including a health care professional, is engaging in fraudulent activity that is not related to claims or other aspects of N.J.S.A. 17:33A-4, the HMO may, nevertheless, investigate the matter. In performing its investigation, the HMO should apply similar standards for determining its investigation is complete, and not act to terminate a health care provider, or report the activity to the Division of Criminal Justice and/or the licensing agency of the health care provider, until the HMO's investigation is complete, as set forth above.

Election not to investigate, and restrictions on termination

Should an HMO elect not to establish a fraud investigation program, the HMO shall not terminate a health care professional on the basis of fraud using the exemption to the 90-day prior notice, written explanation and hearing opportunity established at N.J.S.A. 26:2S-8, unless the activity also constitutes an imminent danger to a member or the public health and welfare. In addition, the HMO shall not deviate from the notice and continuity of care requirements generally applicable for termination of health care professionals solely on the basis of the fraud. The hearing, if any is requested, need not be determinative as to whether fraud occurred, but if not, this fact must be so noted in the record of the hearing.

If an HMO suspects that a participating health care provider may be engaging in fraudulent activity, whether related to claims or not, because the health care provider is the subject of an investigation of a state or federal agency, and not on the basis of any independent investigation by the HMO (whether the HMO has elected not to establish a fraud investigation program, or is simply not investigating in the specific situation), the HMO may terminate a health care professional for fraud pursuant to the exemptions established at N.J.S.A. 26:2S-8, but must not act to terminate any health care provider until such time as the investigation of the state or federal agency is complete, and the agency seeks to take final administrative or other legal action against the health care provider.

With respect to this latter situation, the HMO may terminate a health care professional on the basis of fraud prior to the conclusion of the investigation by the state or federal agency, but may do so only by providing at least 90-days prior written notice, providing the health care professional with the written reason for the termination (upon request) and providing the health care provider an opportunity for a hearing (upon request). The hearing need not be determinative as to whether fraud occurred, but if not, this fact must be so noted in the record of the hearing. In addition, the HMO must comply with all notice and continuity of care requirements with respect to the specific health care professional as are generally applicable to terminated health care professionals, without exception on the basis of fraud.[3]

[3] Of course, if the activity represents an imminent danger to a member or the public health and welfare, immediate termination is permitted.

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HMOs are not required to submit the details of their fraud detection and prevention programs to the Department, nor does the Department believe that HMOs are obligated to make the details of their fraud detection and prevention programs known to health care providers in the general course of business. However, the HMO should have the details of their fraud detection and prevention programs available for review upon request.

Questions regarding this bulletin should be submitted in writing. Questions may be directed to Elisabeth Salberg, Director of the Office of Managed Care within the Department at P.O. Box 360, Trenton, NJ 08625-0360, or at (609) 633-0807 (faxsimile number).