

Health Plus Medical & Claims Payment Bulletin

Bulletin number: CL – B300

Original Bulletin Date: 03/01/06

Updated: 04/24/06

Subject: Fraud and Abuse

Policy:

- Health Plus reserves the right to review claims, and their supporting clinical records, on either a prepayment or post payment basis, in order to detect fraud and/or abuse and to recoup payments made to providers, as appropriate.

This claims review activity may be conducted by the plan itself, or in conjunction with another entity to which the plan delegates its fraud and abuse detection, investigation, and prevention activities.

- Health Plus follows the guidelines set forth in its Fraud & Abuse Prevention Plan Program.
- Providers suspected of engaging in fraud and/or abuse may be placed on prepayment claim review status pending resolution of a sampling of their submitted claims and completion of a fraud and abuse review.

A decision to place a provider on prepayment review status will be made by the Chief Medical Officer or its designee.

- If a provider is suspected of engaging in fraud and/or abuse, Health Plus reserves the right to review claims, and their supporting clinical records, on either a prepayment or post payment basis, within a designated period of time.

Policies in this manual are intended to reflect standard Health Plus procedures. In instances where a provider's contract contains other policies which may be more or less restrictive than those in this manual, these contractual provisions will apply.

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