§ 1348. Antifraud plan

(a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

(b) Every plan shall submit its antifraud plan to the department no later than July 1, 1999. Any changes shall be filed with the department pursuant to Section 1352. The submission shall describe the manner in which the plan is complying with subdivision (a), and the name and telephone number of the contact person to whom inquiries concerning the antifraud plan may be directed.

(c) Every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

(d) Nothing in this section shall be construed to limit the director's authority to implement this section in accordance with Section 1344.

(e) For purposes of this section, "fraud" includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit.

(f) Nothing in this section shall be construed to limit any civil, criminal, or administrative liability under any other provision of law.

HISTORY:

Added Stats 1998 ch 837 § 1 (SB 956). Amended Stats 1999 ch 525 § 48 (AB 78), operative July 1, 2000.