

Compliance and Fraud, Waste and Abuse Prevention Training



Plan on it.





The Health Plan's (THP) Compliance Program and Code of Conduct

THP's Compliance Program

The Social Security Act & the Centers for Medicare and Medicaid Services (CMS) oversees the Medicare program, including Medicare Parts C and D

- Part C and D sponsors must have an effective compliance program, and are obligated to have policies and procedures which include measures to prevent, detect and correct Medicare noncompliance and Fraud, Waste and Abuse (FWA).
- The Health Plan is responsible for the services we delegate to our First Tier, Downstream and Related Entities (FDRs). FDRs may include the providers and practitioners with whom we contract to provide health care services to our Medicare members.

West Virginia Department of Health and Human Resources Bureau for Medical Services oversees West Virginia Medicaid

- The Health Plan must have internal controls, policies, and procedures to prevent and detect fraud and abuse.
- The Health Plan must have a compliance plan that includes the seven elements of an effective compliance program.



You are the Key to Compliance

As a part of the health care delivery system, it is important that we conduct ourselves in an ethical, legal and compliant manner. In addition, we must commit fully to compliance and be vigilant in the detection, prevention and correction of fraud, waste and abuse while administering health care benefits and services.

In addition, if you are a provider of health care services to Medicare and Medicaid beneficiaries, you should have a compliance program that includes the seven elements of an effective compliance program.



Compliance Program Requirements

A compliance program should include seven core elements:

1. Written policies, procedures and standards of conduct
2. Compliance officer, compliance committee and high level oversight
3. Effective training and education
4. Effective lines of communication
5. Well publicized disciplinary standards
6. Effective systems for routine monitoring and identification of compliance risks
7. Procedures and systems for prompt response to compliance issues

42 C.F.R. §§ 422.503(b)(4)(vi) & 423.504(b)(4)(vi); Internet-Only Manual (“IOM”), Pub. 100-16, Medicare Managed Care Manual Ch. 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Ch.9



Code of Conduct



The successful business operation and reputation of The Health Plan is built on the principles of fair dealing and ethical conduct. As a result, The Health Plan has adopted a code of conduct which requires compliance with all applicable laws and regulations. We expect our directors, officers, employees, contractors and FDRs to conduct business in accordance with the letter, spirit, and intent of all relevant laws and to refrain from illegal, dishonest or unethical conduct.



Code of Conduct

What is a Code of Conduct?

- A set of principles and expectations that are considered binding on any person who is a member of a particular group.
- A set of rules that guide behavior, actions and decisions in a specified situation.
- A tool to encourage open discussions of ethics and ethical situations one may face in the workplace.
- An example of how to promote a higher standard of practice within an organization and a positive public image.

All FDRs of The Health Plan should adhere to our code of conduct or their own comparable standards of conduct. The Health Plan code of conduct can be accessed through the following link:

<https://www.healthplan.org/sites/default/files/documents/resources/fraud-waste-abuse/2018%20Compliance%20PlanCoC%20-%20FINAL.pdf>

Reporting FWA and Noncompliance

Responsibility for Reporting Violations

As part of The Health Plan's commitment to compliance, our FDRs are responsible for reporting suspected issues of noncompliance and/or FWA. Because we promote a relationship built on mutual trust and respect, we encourage professionals, providers, contractors and vendors to ask questions about company practices without fear of adverse or retaliatory consequences.

Examples of Potential Violations:

- Violations (noncompliance) of law or policy
- Dishonest or unethical behavior
- Conflicts of interest
- Potential fraud, waste or abuse
- Questionable accounting practices
- Suspicious or weak internal controls



Reporting FWA and Noncompliance



Issues of suspected FWA or noncompliance can be reported to The Health Plan by:

- Contacting The Health Plan Compliance Officer, Jill Medley or Compliance Department (1.800.624.6961, ext. 7638)
- Call The Health Plan Hotline (1.877.296.7283) (can be anonymous)
- Email the Compliance Department at compliance@healthplan.org
- Report through The Health Plan website by using the “Report Fraud” link

There will be **NO** retaliation against anyone for reporting a suspected issue in good faith.



Steps to Promote Compliance

Screen Your Employees

Federal law prohibits the payment of federal health care dollars to persons who are excluded from participation in federal health care programs. You should screen all of your employees through the Office of Inspector General (OIG) List of Excluded Individuals and Entities and the Government Services Administration Excluded Parties List System (SAM). You should conduct these screenings at hire and each month thereafter. You should also maintain records of these screenings for at least ten years.

If you become excluded, or find you have hired an excluded individual, you must notify the Compliance Department at The Health Plan immediately.

The OIG exclusion database can be accessed at:

<https://oig.hhs.gov/exclusions/index.asp>

The SAM exclusion database can be accessed at:

<https://www.sam.gov/portal/SAM/#1>



Steps to Promote Compliance

Train Your Employees

Ongoing Compliance and FWA training is an essential part of an effective compliance program. Training should be completed on an annual basis. Training may be completed through your own internal compliance program or by using training materials provided by The Health Plan, including these training slides.

If you provide health care services to The Health Plan's SNP members, you are required to complete THP Medicare Advantage SNP Training on an annual basis.

THP Medicare Advantage SNP training can be accessed at:
<https://www.healthplan.org/sites/default/files/documents/resources/d-snp/2016%20SNP%20Training%20Deck%20for%20Providers.pdf>



Steps to Promote Compliance

Monitor Your Processes

Ongoing monitoring of your everyday business processes is a vital component of an effective compliance program. You should focus your monitoring efforts on high risk areas such as:

- **Claims submission:** Make sure you have documentation to support every service you bill. Use the correct CPT code and avoid “upcoding” of services to a higher level than the service actually provided. CPT and diagnosis codes change at least annually. Consider using certified coders to make sure your claims are correct. Not only will this keep you out of trouble with federal regulators, correct claims can help you get paid faster.
- **Relationships:** Do not offer, exchange or receive anything in order to induce or be compensated for health care referrals. These types of arrangements can violate the Anti-Kickback Statute or Stark Law.
- **Documentation:** Make sure your medical record documentation is accurate, complete, and can withstand the scrutiny of outside auditors. Resist the urge to base your documentation on canned text or copy/paste functions. Records that appear “cloned” are not viewed favorably by government auditors.



Important Health Care Industry Laws and Regulations



Laws You Need to Know

Deficit Reduction Act

- Section 6032 of the Deficit Reduction Act of 2005, requires any entity which receives or makes Medicaid payments of at least \$5 million annually to establish written policies that include detailed information about the federal **False Claims Act**. These written policies must include information for detecting and preventing FWA and “whistleblower” protections.

Federal False Claims Act (FCA)

- This law allows the government to recover money from individuals or companies that knowingly submit false claims for payment, make a false record to get a claim paid, conspire against the government to get a false claim paid, or make a record to conceal or avoid an obligation to pay the federal government. The Federal False Claims Act includes “whistleblower” provisions and steep penalties for violations.

Examples of Potential False Claims

- Adding a diagnosis not supported by the medical record to a member's record in order to trigger payment
- Billing an established patient using new patient codes in order to trigger higher reimbursement
- Billing a patient visit under the physician's NPI when the patient was seen by a midlevel provider and Medicare's incident-to rules are not met
- Billing for services that were not done or were not medically necessary
- Using a false diagnosis in order to meet coverage criteria in order to trigger payment



More About the False Claims Act

False Claims Act (Qui Tam) Whistleblower Provisions

The False Claims Act permits private individuals to file suit on behalf of the federal government. This is referred to as whistleblower or Qui tam provisions. A whistleblower is someone who reports to an employer, a regulatory body, or an oversight or review authority the violation of a law or regulation. The False Claims Act prohibits retaliation to an employee who files a good faith report to his or her employer or a government agency.

False Claims Act Fines and Penalties

Fines and penalties under the federal False Claims Act include triple damages and penalties in the amount of \$10,957 to \$21,916 for each false claim. These per claim damages are adjusted annually.



Laws You Need to Know

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Kickbacks can take many forms such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or co-insurance. Penalties for anti-kickback violations include fines of up to \$25,000, imprisonment for up to five years, civil money penalties up to \$50,000, and exclusion from participation in federal health care programs.

The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))

This statute makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.



Laws You Need to Know

Fraud Enforcement and Recovery Act (FERA) of 2009

FERA made significant changes to the False Claims Act (FCA). FERA makes it clear that the FCA imposes liability for the improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids or decreases an “obligation” to pay money to the government.

Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)

Federal law make it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offense carries a criminal penalty of up to five years in prison and a monetary fine.



Laws You Need to Know

Exclusions (42 U.S.C. §1395(e)(1) and 42 C.F.R. §1001.1901)

Federal law prohibits payment for services provided by an individual or entity excluded from participation in a federal health care program.

Physician Self-Referral (“Stark”) Statute (42 U.S.C. § 1395nn)

The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law also prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment/refund obligations, FCA liability, and civil monetary penalties. Stark Law is a “strict liability” statute and does not require proof of intent.



Laws You Need to Know



Health Insurance Portability and Accountability Act (HIPAA)

The **HIPAA Privacy Rule** requires health care providers to protect the privacy of their patients' health care information. This information is called protected health information or PHI.

The **HIPAA Security Rule** requires health care providers to implement administrative, physical and technical safeguards to protect electronic PHI (ePHI). In addition, health care providers are required to perform periodic HIPAA security risk assessments and remediate deficiencies found during the risk assessment that threaten the security of ePHI.

HIPAA requires health care providers obtain an authorization from the patient before using or disclosing the patient's PHI. HIPAA does allow the use and disclosure of PHI without patient authorization as long as the use or disclosure is for treatment, payment, health care operations (TPO) or for certain other disclosures required by law. However, uses and disclosures should be limited to the minimum amount of information necessary. This is called "minimum necessary" under HIPAA.

More About HIPAA

Patient Rights Under HIPAA

HIPAA gives patients important rights with regards to their PHI. Patients have the right to:

Receive a Notice of Privacy Practices: This notice explains how you will use and disclose your patient's PHI. You are required by law to provide this notice or NPP to your patients. Sample NPPs are available on the Office for Civil Rights website through the following link.

<https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html>

Access Their PHI: Patients have a right to access their PHI. A provider cannot deny access because a patient has not paid for health care services. You may charge a reasonable cost based fee for providing copies to the patient but you may not charge a search fee or more than the cost of producing the record even if state law allows you to charge more.

Request Confidential Communications: Patients have a right to ask you to contact them through alternative means such as by cell phone rather than home phone.



More About HIPAA

Patient Rights Under HIPAA (cont.)

Request a Restriction: Patients have the right to request limits on how you use and disclose their PHI. You do not have to honor their request unless they have asked you not to submit information to their health insurance company and they paid for the health care services up front and in full.

Amend or Correct their PHI: Patients have a right to request an amendment or correction to their PHI. If you believe the patient's medical record is correct and accurate, you do not have to make the requested change but the patient may submit a statement of disagreement that must be added to the record.

Receive an Accounting of Disclosures: Patients have a right to receive a list of disclosures you have made of their PHI. You must provide the accounting within 60 days of the patient's request.

File a Complaint: Patients have a right to file a complaint if they believe you have violated their HIPAA rights.



Fraud, Waste and Abuse (FWA) Detection and Prevention



Why Focus on FWA?

Health care scams cost the healthcare industry more than \$80 billion annually (2017 Coalition Against Insurance Fraud).

Fraud, Waste & Abuse (FWA) programs save Medicare dollars and benefit taxpayers, the government, health plans and beneficiaries.

Detecting, correcting and preventing FWA requires collaboration between:

- Health plans
- Providers of services such as hospitals, physicians, nurses, and pharmacies
- State and federal agencies
- Beneficiaries (members and patients)

Fraud, Waste and Abuse Facts

- The typical organization loses 5% of its annual revenue to fraud
- Smaller organizations often suffer the largest losses
- Schemes can continue for months or even years before they are detected
- Drug diversion cases individual private insurers up to \$857 million annually



FWA Definitions

Fraud: The intentional use of deception for unlawful gain or unjust advantage.

Waste: The overutilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse: Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practices.



The What and Who of Fraud

WHAT:

Fraud occurs when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or some other individual.

WHO:

- Physicians or other practitioners
- Hospitals or other institutional providers
- Clinical Laboratories or other suppliers
- Employees of any provider
- Billing services
- Beneficiaries
- Medicare contractor employees
- Any individual in a position to file a claim for a Medicare or Medicaid benefit

Fraud schemes range from individuals acting alone to broad-based activities by institutions or groups of individuals in collusion. Sometimes these activities employ sophisticated telemarketing and other promotional techniques to lure consumers into serving as unwitting tools. Seldom will perpetrators target only one insurer or the public or private sector exclusively. Most schemes defraud both sectors with no specificity, including Medicare & Medicaid.



Examples of Fraud

- Incorrect reporting of diagnoses or procedures to maximize payment
- Billing for services not furnished and/or supplies not provided including billing Medicare or Medicaid for missed appointments
- Billing that appears to be a deliberate application for duplicate payment
- Altering claim forms, electronic claim records and/or medical documentation to obtain a higher payment amount
- Soliciting, offering or receiving a kickback, bribe or rebate
- Offering something of value in exchange for referrals of diagnostic tests, services or medical equipment which are then billed to Medicare or Medicaid.
- Unbundling or “exploding” charges
- Completing certifications of medical necessity for patients unknown by the provider or supplier
- Billing based on “gang visits” such as a physician visiting a nursing home and billing for 20 nursing home visits without furnishing any specific service to individual patients
- Misrepresentations of dates, services furnished, the identity of the beneficiary or the individual who furnished the services
- Billing non-covered or non-chargeable services as covered items
- Using another person's Medicare or Medicaid card to obtain medical care.

Examples of Member Fraud



- Card sharing or loaning/using another person's insurance card
- Obtaining prescriptions under false pretense
- Forging or selling prescription drugs
- Providing false information for the purpose of obtaining benefits
- Misrepresenting a medical condition
- Failing to report a change in family status such as divorce or a change in dependent coverage

Anyone
(i.e., employee, volunteer, provider, member, Board of Directors) can report abuse or compliance issues.

Your report will be confidential and can be reported anonymously.

To report suspected fraud, waste or abuse and/or suspected compliance issues call the hotline number shown here.

You may report anonymously. There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.



What is Abuse?

Abuse describes a practice that either directly or indirectly results in unnecessary cost to an insurer, specifically Medicare or Medicaid. Fraud differs from abuse because fraud is committed knowingly, willfully and intentionally.

Abusive billing practices may not result from “intent” or it may be impossible to determine if the intent to defraud exists. However, abusive practices may develop into fraud if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Examples of Abuse

- Charging in excess of services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Submitting bills to Medicare or Medicaid when another carrier is primary
- Violating the participating provider agreement with Medicare or Medicaid
- Violating the maximum actual charge limit or the limitation amount

Reporting Fraud, Waste and Abuse

- To report a suspect incident, complete The Health Plan website form found by clicking on the orange link labeled **“Report Fraud”**. This button is found at the bottom right of every page on the website, and provides online access to the Fraud Suspect Activity Form/Reporting Mechanism.
- You may also call THP’s Fraud Hotline at **1.877.296.7283**.
- You can send an email to compliance@healthplan.org
- If you would like to speak to the Compliance Officer you may reach **Jill Medley** at **1.800.624.6961, ext. 7693**.

To report ***anonymously** please use the form on healthplan.org or call **1.877.296.7283**

*The hotline number does not use caller ID to ensure anonymity.