TheHealthPlan

Chapter 12

Compliance

Provider Manual

Provider Reimbursement

Providers must inform members non-covered services costs prior to rendering non-covered services. Providers may not bill or collect any payment from members for care that was determined not medically necessary. Providers may not balance bill members.

Providers are prohibited from collecting copays for missed appointments. Members are held harmless for the costs of all covered services provided, except for any cost-sharing obligations.

Providers are required to treat all information obtained through the performance of the services in THP contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations.

THP does not discriminate against providers acting within the scope of their license and shall not face discrimination with respect to participation, reimbursement, or indemnification. Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the member needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.

THP may not make specific payments, directly or indirectly, to a practitioner or practitioner group as an inducement to reduce or limit medically necessary services furnished to any particular member.

Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

THP will provide information to members regarding their rights and responsibilities and any changes upon enrollment, annually, and at least thirty (30) days prior to any change in their benefits.

Fraud, Waste and Abuse Regulations and Guidelines

Fraud, Waste, and Abuse (FWA) Policies and Related Laws

The Health Plan's (THP) fraud, waste, and abuse policies were established to prevent, detect, and correct fraudulent, wasteful, or abusive practices perpetrated by employees, members, practitioners, and facilities, including provider facilities not contracted with THP. Compliance with these policies is the responsibility of every employee and anyone providing services to THP members.

Providers should ensure that all staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. THP expects its first tier, downstream, and related entities (FDRs), its West Virginia Medicaid and West Virginia Children's Health Insurance Program (CHIP) Subcontractors, and its contracted providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare Advantage and West Virginia Mountain Health Trust (MHT) (including WV Medicaid, and WV CHIP) program requirements including, but not limited to the following:

1. **Health Care Fraud (18 U.S.C. §1347)**
   The Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute or attempt to execute a scheme to defraud any healthcare benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a healthcare benefit program in connection with the delivery of, or payment for, health care benefits.
2. **Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)**
   The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:
   a. Knowingly submitting a false or fraudulent claim for payment to the United States government;
   b. Knowingly making a false record or statement in order to get a false or fraudulent claim paid or approved by the government;
   c. Conspiring to defraud the government to get a false or fraudulent claim paid or approved by the government; or
   d. Knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
3. **Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)**
   Federal law makes 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.

4. **Anti-Kickback Statue (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, imprisonment for up to five years, civil monetary penalties, and exclusion from participation in federal health care programs.

5. **The Beneficiary Inducement Statue (42 U.S.C § 1128A(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.

6. **Physician Self-Referral ("Stark") Statue (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.

7. **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 or Medicaid overpayment. Consequently, a health care provider may violate the FCA if it conceals, improperly avoids, or decreases an "obligation" to pay money to the government.

FWA Reporting

THP's Special Investigations Unit (SIU) and Compliance Department actively review all reports of suspected FWA and non-compliance. To report suspected fraud, waste, or abuse and/or suspected non-compliance, call the hotline at 1.877.296.7283. THP maintains a non-retaliation policy for anyone reporting issues in good faith; everyone should feel confident that NO adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

Special Investigations Unit (SIU)

MHT and Medicare Advantage guidelines require THP to implement an effective program to prevent, detect, and correct fraud, waste, and abuse. THP values its relationship with providers and recognizes the importance of providing valuable care to the community. THP is committed to ensuring quality care for its members and proper payment to providers for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship, honoring the commitment to THP's network and its members, and ensuring compliance with federal regulations.

THP's SIU plays a vital role in detecting, preventing, and correcting fraud, waste, and abuse, ensuring payment integrity, and recovering overpayments as required by state and federal regulations. SIU activities may include, but are not limited to, data mining, pre- and post-payment reviews, site visits, audits, and the facilitation of provider self-audits. In the event fraud or abuse is suspected, the case is referred to the appropriate regulatory authorities and/or law enforcement.

The SIU utilizes a skilled team capable of analyzing, auditing, and investigating claims. Providers may be contacted by the SIU as a result of routine post-payment monitoring, or in response to a specific concern. Providers are expected to cooperate with the SIU and must comply promptly with requests for records or other information to ensure timely completion of audits and reviews.

Medical records are reviewed by the SIU, using national published guidelines from various sources which may include, the American Medical Association, American Academies, and the Centers for Medicare and Medicaid Services.

Network providers are contractually required to provide member medical records to THP upon request and within a reasonable period. Subject to the volume of records requested, the SIU routinely specifies fifteen (15) calendar days is a reasonable period of time. Failure to submit the requested records within the stated time may result in an adverse impact on payment of future claims.

Provider Self-Audits

All parties have an obligation to ensure that submitted claims are billed and paid properly. Federal and state regulations require managed care organizations that serve the MHT and Medicare populations to have procedures in place designed to detect and prevent fraud, waste, and abuse.

THP is committed to promoting payment integrity across all lines of business. In furtherance of this objective, the SIU may review paid claims, either as part of a proactive payment integrity program, or in response to specific allegations. One tool the SIU incorporates into its payment integrity processes is the provider self-audit.

A provider self-audit is an audit, examination, or review performed by and within a provider's business. A self-audit may be performed proactively by a provider as part of its own efforts to ensure payment integrity or at the direction of THP based on the discovery of questionable billing patterns. Self-audits are often preferred by providers because they are reviewing their own records, versus having SIU staff and/or government regulators on-site conducting an in-depth review.

Additionally, a self-audit process is generally educational for the provider and its billing staff, resulting in a greater likelihood of future compliance.

Self-audits will be narrowly focused while still sufficient to address the relevant issues and will be limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. Clear indications that an overpayment occurred;
2. An overpayment is likely to be expansive;
3. No previous or immediate indicators of intent to defraud; and
4. High likelihood that the issue(s) can be resolved without significant SIU intervention.

Providers will be notified in writing when a self-audit is required. Self-audits will be developed on a case- by-case basis, depending on the specific circumstances giving rise to the audit. However, in all instances a self-audit notification will include the purpose of the self-audit, the universe of claims to be reviewed and how that universe was determined, a deadline for audit completion, and instructions on how to remit any overpayments. Overpayments made under any federal health insurance program must be recovered. Refer to **Chapter 3 - Claims**, in this manual for timelines and processes related to overpayment recoveries.

The self-audit results will be reviewed by THP. The SIU may review documentation to validate the results and/or may meet with the provider or its staff to discuss any questionable items or further concerns. The provider should maintain copies of self-audit information and documentation for future reference. The provider will be notified in writing upon conclusion of the self-audit review.

Acceptance of a provider self-audit or subsequent repayment does not necessarily constitute agreement with the audit results or the overpayment amount if it is later discovered that the self-audit results contained material misrepresentations or that supporting documentation or other relevant information was altered.

SIU Corrective Action Plan (CAP)

Upon completion of a retrospective payment review by the SIU, if severe, complex, or numerous deficiencies are identified resulting in overpayment--though not sufficient to warrant other actions required for suspected fraud or abuse--it may be appropriate to institute a corrective action plan (CAP). A CAP is a step-by-step plan of action to help achieve desired outcomes by ensuring all outstanding issues or deficiencies identified through the SIU's review process have been addressed and corrected by the provider. During this collaborative process, the provider will be notified in writing of those issues identified by the SIU and requested to submit a self-developed, CAP on how the deficiencies will be addressed. The CAP is required to be submitted to THP within 30 days of the date of the notice. Within the CAP, the provider should list the effective date the corrective action occurred or will occur for each identified discrepancy. Upon receipt and acceptance of the corrective action plan by THP, the provider will be given reasonable times to make the corrections outlined within the plan. Additional review or audit by the SIU may be conducted (typically within 90 days of acceptance of the CAP) to assess compliance and effectiveness of the CAP. Additional reviews may be conducted, as needed, until the identified discrepancies have been adequately addressed.

Compliance Provider Training Programs

THP prepares the following education programs to encourage compliance. THP also issues provider communications to facilitate preventative actions.

1. Fraud Waste Abuse (FWA)

All practitioners and staff members who render health care services to Medicare Advantage enrollees, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to MHT recipients should complete FWA training.

- Practitioners are not required to send attestation to THP, although must maintain evidence of training for at least ten (10) years. This may be in the form of attestations, training logs, or other means sufficient to document completion of these obligations.

2. Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

Annual D-SNP Model of Care training is required for Medicare Advantage practitioners and out of network practitioners that render care to D-SNP enrollees. Training and attestation are located on the secure provider portal.

3. Cultural Competency, Implicit Bias, and Social Determinants of Health (SDoH)

To ensure that providers provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) provider education. THP's Cultural Competency/Social Determinants of Health Training is available on THP's secure provider portal Resource Library. THP's Practice Management Consultants (PMC) are available for individualized education sessions.

4. Motivational Interviewing

To ensure staff and practitioners establish a respectful stance with patients, coworkers, etc. with a focus on building rapport in the initial stages of the relationship. Motivational interviewing has observable practice behaviors that allow practitioners to receive clear and objective feedback from a consultant or staff member.

Examples of Motivational interviewing elements:

- Partnership – Helping people change
- Acceptance – Understanding a person's experiences and perspectives
- Compassion – Promoting a person's wellbeing and expressing empathy
- Plan – Organizing a plan based on a person's insights
- Engage – Listening carefully and acknowledging strengths

To request any of the above as an individualized training session, please contact your PMC. Otherwise, please visit THP's provider portal Resource Library for training materials.

Compliance Through Reporting

THP believes it is the duty of every person who has knowledge or a good faith belief of a potential compliance issue to promptly report the issue or concern upon discovery. This reporting obligation applies even if the individual with the information is not able to mitigate or resolve the problem. This obligation applies to all THP's first tier, downstream, and related entities (FDRs), MHT Subcontractors, and contracted providers.

THP also believes that an issue involving potential or actual non- compliance or FWA can be best investigated and remediated if an entity feels comfortable reporting such incidents through designated channels. There are various mechanisms available to confidentially report compliance concerns or suspected FWA.

- If your organization does not maintain a confidential FWA and compliance reporting mechanism, THP provides various reporting resources including a confidential FWA and

  compliance hotline at 1.877.296.7283, email at compliance@healthplan.org, SIU@healthplan.org or on our website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, providers, and contractors to report potential issues involving FWA and/or non-compliance.
- THP has adopted and requires all FDR, Subcontractors, and providers to adopt and enforce a zero-tolerance policy for intimidation or retaliation against anyone who reports, in good faith, suspected or actual misconduct.

Federal law prohibits payment by Medicare Advantage, West Virginia Medicaid, West Virginia Children's Health Insurance Program (WV CHIP) or any other federal health care program for an item or service furnished by a person or entity excluded from participation in these federal programs. THP, its FDRs, Subcontractors, and contracted providers are prohibited from contracting with, or doing business with, any person or entity that has been excluded from participation in these federal programs. Prior to hire and/or contracting, and monthly thereafter, each FDR, Subcontractor, and provider must perform a check to confirm its employees, governing body, volunteers, and downstream entities that perform administrative or health care services for THP Medicare Advantage and MHT lines of business are not excluded from participation in federally-funded health care programs according to the OIG List of Excluded Individuals and Entities and the General Service Administration's System for Award Management (SAM) exclusion databases.

- Office of Inspector General (OIG) list of excluded individuals and entities: exclusions.oig.hhs.gov
- General Services Administration (GSA) System for Award Management (SAM): https://sam.gov/content/exclusions

- In the event any employees or downstream entities are found on either of these exclusion lists, they must be immediately removed from work related directly or indirectly to THP's Medicare Advantage and MHT programs. You must also notify THP of the finding.
- Practitioners must maintain a record of exclusion list reviews (i.e., logs or other records) to document that each employee and downstream entity has been checked through the exclusion databases in accordance with current laws, regulations, and CMS requirements.
- For further information on exclusion list requirements, refer to §1862(e)(1)(B) of the Social Security Act, 42 C.F.R. §422.752(a)(8), 42 C.F.R. §423.752(a)(6), 42 C.F.R. §1001.1901, the CMS Managed Care Manual, Chapter 21, Section 50.6.8 and the CMS Prescription Drug Benefit Manual, Chapter 9, Section 50.6.8.

HIPAA Privacy and Security

THP is committed to ensuring the confidentiality, integrity, and availability of our members' protected health information, or PHI. PHI includes individually identifiable information that relates to an individual's past, present, or future health care or payment for health care whether in written, spoken, or electronic form.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires covered entities such as THP and healthcare providers to:

- Properly secure PHI (physically and electronically)
- Protect the privacy of member/patient PHI
- Abide by the "minimum necessary" standard for the use and disclosure of member/patient PHI
- Address members'/patients' rights for the access, use, and disclosure of their health information

The Health Information Technology for Economic and Clinical Health (HITECH) Act and the HIPAA Final Omnibus Rule updated the original federal HIPAA privacy and security standards to include:

- Requirements for breach notification
- Members'/patients' rights to obtain electronic copies of their electronic health record
- Makes business associates directly liable for compliance with certain HIPAA provisions
- Increased fines and penalties for violations, including civil penalties, criminal penalties, and imprisonment

Who Does HIPAA Apply To?

HIPAA laws and regulations apply to health plans, health care providers, and health care clearinghouses as well as business associates who perform services on their behalf.

Safeguarding PHI

Here are some ways to protect member/patient information:

- Use PHI only when necessary, as part of job duties
- Use only the minimum necessary information to perform job duties
- Double check printers, faxes, and copiers when finished using them
- Never leave PHI unattended in a bag, briefcase, or vehicle
- When mailing documents, verify that each page belongs to the intended recipient
- Ensure that computers are locked when unattended
- Create strong passwords, and never share usernames or passwords
- Do not install unknown or unsolicited programs onto work computers
- Ensure that information on monitors/screens is not visible to patients or visitors
- Never share patient information through social media, even if it is public knowledge
- When discussing patient care, take steps to reduce the likelihood others will overhear
- Keep paper documents that contain PHI out of view from others
- Dispose of PHI properly when no longer needed.

These are just a few ways to help ensure the confidentiality of patient PHI. Truly protecting the information that is entrusted to healthcare providers requires a commonsense approach that depends upon strict adherence to established policies and procedures.

THP has implemented HIPAA-related training for all its employees, which is distributed to staff upon hire and annually thereafter. It is recommended that all entities who work with PHI establish their own privacy and security program for their individual organization, and execute an inclusive, well- rounded training regimen to keep employees informed of their responsibilities surrounding patient/member rights and protections under the law.

HIPAA information and related forms can be found on our corporate website, healthplan.org using the links "HIPAA Notice of Privacy Practices" and "HIPAA Privacy Information and Forms."

Resources:

1. U.S. Department of Health and Human Services- Office for Civil Rights (OCR):

   https://www.hhs.gov/ocr/index.html

2. HIPAA Frequently Asked Questions for Professionals (FAQs): **hhs.gov/hipaa/for-professionals/faq**
3. Heath Care Compliance Association (HCCA): **hcca-info.org**
4. Society of Corporate Compliance and Ethics (SCCE): **corporatecompliance.org**
5. National Health Care Anti-Fraud Association (NHCAA): **nhcaa.org**
6. Institute for Health Care Improvement (IHI): **ihi.org**
7. A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse: **oig.hhs.gov/compliance/physician-education/index.asp**
8. Compliance Guidance for Individual and Small Group Physician Practices: **oig.hhs.gov/authorities/docs/physician.pdf**
9. General Compliance Program Guidance: **https://oig.hhs.gov/compliance/general-compliance-program-guidance/**
10. Health Insurance Portability and Accountability Act (HIPAA): **hhs.gov/hipaa/for-professionals/index.html**
11. Stark Law (Physician Self-Referral):

    cms.gov/Medicare/Fraud-and-abuse/physicianselfreferral/index