TheHealthPlan

Chapter 13

Compliance

Practitioner Reimbursement Compliance

Practitioners must inform members of costs of non-covered services prior to rendering the non-covered services. Practitioners may not balance bill or collect any payment from members for care that is determined to be not medically necessary.

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

Practitioners are required to treat all information obtained through the performance of services as confidential information to the extent that confidential treatment of such information is required under state and federal laws, rules, and regulations.

The Health Plan (THP) does not discriminate against practitioners acting within the scope of their license. Practitioners shall not face discrimination with respect to participation, reimbursement, or indemnification. Healthcare professionals, acting within their lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of a member with respect to their medical care or treatment options (including any alternative treatments); any information the member needs to decide among available treatment options; or the risks, benefits, and consequences of treatment or no treatment.

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

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

Participating and non-participating practitioner reimbursement is conditioned upon compliance with THP's benefit coverage determinations, medical necessity criteria, prior authorization requirements, coding rules, and reimbursement policies applicable to the member's benefit plan. A non-participating practitioner's acceptance of assignment of benefits does not create a practitioner participation agreement or confer any contractual rights beyond payment in accordance with applicable plan policies and state and federal regulations or laws.

Fraud, Waste and Abuse Regulations and Guidelines

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

THP's FWA policies were established to prevent, detect, and correct fraudulent, wasteful, or abusive practices perpetrated by employees, members, and participating or non-participating practitioners. Compliance with these policies is the responsibility of anyone rendering services to THP members.

Practitioners should ensure that all staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place. THP expects its contracted practitioners to operate in accordance with all applicable federal and state laws, regulations, and program requirements, including Medicare Advantage, West Virginia Medicaid, and West Virginia Children's Health Insurance Program (WV CHIP). Pertinent laws include, but are 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 False Claims Act (31 U.S.C. §§ 3729)

The Federal False Claims Act (FCA) prohibits any person from knowingly submitting false claims for payment, making a false record to get a claim paid, conspiring against the government to get a false claim paid, or making a record to conceal or avoid an obligation to pay the federal 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 practitioner, or supplier, including a retail, mail order or specialty pharmacy.

6. Physician Self-Referral ("Stark") Statue (42 U.S.C § 1395nn)

Stark Law prohibits a physician from referring Medicare members 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 FCA. FERA makes it clear that the FCA imposes liability for the improper retention of Medicare or Medicaid overpayments. Consequently, a health care practitioner may violate the FCA if it conceals, improperly avoids, or decreases an "obligation" to pay money to the government.

8. Requirements for Reporting and Returning of Overpayments (42 CFR § 401.305)

Federal regulations require overpayments of federal funds for Medicare or Medicaid services to be reported and returned within 60 days of identification. The rule suspends the obligation to report the overpayment for up to 180 days if, after identifying a potential overpayment, the practitioner conducts a timely, good-faith investigation to determine whether an overpayment exists. Failure to report or return an overpayment within the specified period of time may trigger FCA liability. See **Chapter 3 – Claims** for additional information related to practitioner overpayments.

FWA Reporting

THP's Special Investigations Unit (SIU) and Compliance Department review all reports of suspected FWA and non-compliance. To report suspected FWA 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 meaning that no retaliation will be taken for reporting issues of concern. All issues may be reported anonymously.

Special Investigations Unit (SIU)

Medicare and Medicaid guidelines require THP to implement an effective program to prevent, detect, and correct FWA. THP values its relationship with practitioners and recognizes the importance of providing care to the community. THP is committed to promoting quality care for its members and proper payment to its practitioners for services rendered. Safeguarding payment integrity is an integral part of maintaining this mutually beneficial relationship. THP's SIU plays a vital role in detecting, preventing, and correcting FWA. The SIU does this by conducting investigations and recovering overpayments as required by state and federal regulations.

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

Medical records are reviewed by the SIU using national guidelines from various sources, which include the American Medical Association (AMA) and CMS. Practitioners are contractually required to provide medical records to THP upon request. Failure to submit requested medical records within the stated timeframe may impact the payment of future claims, the practitioner's network status, and/or result in the initiation of other legal remedies, as applicable.

See Chapter 4 – Medical Records for additional information related to medical records.

There are many tools that the SIU uses to promote payment integrity and to prevent and detect FWA. These tools include, but are not limited, to the following:

1. Post-Payment Reviews

In response to the receipt of a reported allegation of FWA or as a result of proactive datamining, the SIU may initiate post-payment review to determine if the reported allegation has merit. The post-pay review investigation may include a review of information from publicly available sources, member interviews or surveys, practitioner interviews, site visits, and/or medical record reviews. Practitioners may not receive advance notice that they are the subject of a post-payment review. Practitioners who receive a notice of review and/or a request for medical records may not receive the status of the review until its completion (subject to the requirements of the practitioner contract and/or applicable state and federal regulations).

Upon completion of a review, the SIU will notify the practitioner of any overpayments identified, providing educational resources, as applicable.

2. Practitioner Self-Audit

A practitioner self-audit is an audit, examination, or review performed by and within a practitioner's business. A self-audit may be performed proactively by practitioners as part of their 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 practitioners because they review their own records, as opposed to SIU staff or government regulators. Self-audits are intended to be narrowly focused while still sufficient to address relevant issues. Self-audits are generally limited in scope and duration. Self-audits may be utilized for cases meeting the following criteria:

1. There are clear indications that overpayment has occurred;
2. The overpayment is likely to be systemic and/or extensive;
3. There are no previous or immediate indicators of intent to defraud; and
4. There is a high likelihood that the issue(s) can be resolved without significant SIU intervention

Practitioners are notified in writing when a self-audit is required. Self-audits are developed on a case-by-case basis, depending on the specific circumstances. However, in all instances the self-audit notification includes the purpose of the self-audit, parameters of claims to be reviewed including how the parameters were determined, deadline for audit completion, and instructions on how to remit any identified overpayments. Overpayments made under any federal health insurance program must be returned to the payer. Refer to **Chapter 3 - Claims** for timelines and processes related to overpayment recoveries.

3. Pre-Payment Review (PPR)

PPR is a process used to confirm that services are appropriately documented and billed prior to claims payment. PPR may be utilized when questionable or inappropriate billing patterns are identified or if a practitioner is suspected to be at risk of FWA, but where clear indices of fraud have not been identified. Practitioners may be referred to PPR by the West Virginia Bureau for Medical Services or by internal sources. Internal sources of PPR referrals include internal monitoring, post-payment review results, receipt of complaint(s), routine claims processing, and/or data mining.

Practitioners subject to PPR are notified in writing prior to the PPR effective date. The PPR notification includes relevant information regarding the reason(s) for the PPR, the date when a practitioner will be required to begin submitting documentation for claims adjudication, claim codes or types of claims subject to PPR, and the TIN(s) subject to PPR.

During the PPR period, practitioners are required to submit medical records and other documentation as applicable to support the services billed. PPR claims should be submitted with sufficient documentation to substantiate the nature, extent, and appropriateness of the billed services.

Failure of the practitioner to submit the required documentation or meet minimum documentation standards will result in claim denial.

Upon the conclusion of PPR, the practitioner is notified in writing that PPR has concluded, and any outstanding concerns and next steps.

THP reserves the right to conduct concurrent or subsequent post-payment reviews in response to any findings identified during PPR. THP also reserves the right to require a practitioner self-audit of previously

paid claims for compliance with applicable policies/rules/regulations. PPR is separate and distinct from other prior authorization and/or pre-adjudication requirements.

Corrective Action Plan (CAP)

Upon completion of a payment integrity activity, e.g., post-payment review, PPR, or self-audit, it may be appropriate to initiate a CAP. A CAP is required when a payment integrity activity reveals significant, complex, or material deficiencies. If a CAP is required, the practitioner is notified in writing of the issues subject to the CAP. The practitioner develops the CAP action items and submits it to THP for approval. Upon receipt and acceptance of the CAP by THP, the practitioner will be given a reasonable period of time to complete the corrections outlined within the CAP. Additional review or audit by THP may be conducted to assess the effectiveness of the CAP and to confirm the identified deficiencies have been adequately addressed.

SIU Overpayment Determinations/Demands for Repayment

Upon completion of a review, the SIU may determine that an overpayment has been made. The SIU will notify the practitioner in writing of the overpayment and make demand for repayment. This notification generally contains a list of affected claims along with the reason each claim line item was identified as an overpayment. Demands for repayment will abide by all applicable state and federal regulations and statutes.

SIU Overpayment Determination Appeals

The practitioner has 40 calendar days from the date of notification letter, or a period of time as required by state law, to file an appeal or dispute of the overpayment. The practitioner's written request must cite the reason(s) for disputing the overpayment determination (specific to the individual claims lines, where applicable) and should include applicable supporting documentation. The appeal will be reviewed by a secondary reviewer who did not participate in the initial overpayment determination.

If an appeal or dispute is not made within the appeal timeframe, the applicable recoupments will be made in accordance with **Chapter 3 - Claims** of this manual.

There are no appeal rights granted for overpayment determinations made as a result of a practitioner self-audit.

Practitioner Compliance Training

THP prepares the following education programs to encourage compliance. THP also issues practitioner communications to facilitate preventative actions and has a team of Practice Management Consultants (PMC) available for individualized education sessions. Visit THP's corporate website at healthplan.org or secure provider portal at myplan.healthplan.org for more information on these trainings.

1. Fraud Waste Abuse (FWA)

All practitioners and staff members who render health care services to Medicare Advantage members, provide Medicare Part C services, administer the Medicare Part D prescription drug benefit, or provide services to MHT members should complete FWA training. Practitioners should complete their own FWA training or use documents provided by THP. Practitioners are not required to send a training attestation to THP but must maintain evidence of training for at least ten (10) years. This documentation may be in the form of attestations, training logs, or other means sufficient to provide evidence of completion of these requirements.

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

Annual D-SNP MOC training is required for participating Medicare Advantage practitioners and out-of-network practitioners that render care to THP's D-SNP enrollees.

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

To ensure that practitioners provide services in a culturally competent manner, THP developed cultural competency and social determinants of health (SDoH) practitioner education.

4. Motivational Interviewing

To ensure staff and practitioners establish a respectful stance with members, coworkers, and other stakeholders, practitioners should practice motivational interviewing techniques. Motivational interviewing allows practitioners to receive clear and objective feedback from members and other staff members.

Motivational interviewing elements include:

- 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

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 cannot mitigate or resolve the problem.

THP also believes that an issue involving potential or actual non-compliance or FWA can be best investigated and remediated if an individual 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 THP's corporate website at healthplan.org. These reporting mechanisms are available and widely publicized to all employees, practitioners, and contractors to report potential issues involving FWA and/or non-compliance.
- THP adopted and requires all practitioners 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, WV Medicaid, 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 and its contracted practitioners 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 practitioner must perform a check to confirm its employees and others that perform administrative or health care services for THP's 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: https://exclusions.oig.hhs.gov/General Services Administration (GSA) System for Award Management (SAM): https://sam.gov/content/exclusions
- In the event anyone is 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, e.g., logs or other records, to document that each employee has been checked through the exclusion databases in accordance with current laws, regulations, and CMS requirements.

HIPAA Privacy and Security

THP is committed to ensuring the confidentiality, integrity, and availability of its members' protected health information (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 practitioners to:

1. Properly secure PHI
2. Protect the privacy and security of member PHI
3. Abide by the "minimum necessary" standard for the use and disclosure of member PHI
4. Abide by individual rights such as the right of individuals to access their health information
5. Notify individuals and the Department of Health and Human Services in the event an individual's PHI is breached

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

THP recommends that entities who work with PHI establish a privacy and security program for their individual organization including the execution of a training program that addresses HIPAA requirements. For more information about HIPAA, visit the Office for Civil Rights' website at https://www.hhs.gov/hipaa/index.html. More information related to THP's HIPAA policies and procedures can be found on THP's corporate website at healthplan.org → "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