Compliance & Fraud, Waste and Abuse Prevention Training
The Health Plan’s (THP) Compliance Objectives and Code of Conduct
OBJECTIVES

• Meet the regulatory requirement for training & education
• Provide information on the scope of fraud, waste and abuse also known as FWA
• Explain the obligation of everyone to detect, prevent and correct FWA
• Provide information on how to report non compliance and FWA
• Provide information on laws pertaining to compliance and FWA
The Social Security Act & CMS govern the Medicare program, including Parts C and D

- Part C and D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non compliance as well as FWA.

- Sponsors (THP) must have an effective training for employees, volunteers/contractors and governing boards as well as first tier, downstream and related entities. (42 C.F.R. 422.503 & 423.504)
A compliance program, at a minimum, must include these 7 core requirements:

1. Written Policies, Procedures & Standards of Conduct
2. Compliance Officer, Compliance Committee & High Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well Publicized Disciplinary Standards
6. Effective System for Routine Monitoring & Identification of Compliance Risks
7. Procedures & System 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; ION, Pub. 100-18, Medicare Prescription Drug Benefit Manual Ch.9
As a person who provides health or administrative services to a Part C or Part D enrollee you are either a:

- Part C or D Sponsor employee (THP)
- First Tier Entity (PBM such as ESI, Contracted Sales Agents or a Claims Processing company)
- Downstream entity (Pharmacy)
- Related Entity (any entity that is related to the MA organization by common ownership or control)
THP’s successful business operations and reputation have been built upon a solid commitment to the principles of fair dealings along side ethical conduct of our employees.

Our reputation for integrity and excellence require that we carefully observe the spirit of all applicable laws and regulations, as well as a scrupulous regard for the highest standards of conduct and personal integrity.
This training module will assist Medicare Parts C & D plan sponsors in satisfying the Compliance training requirements of the Compliance Program for:

- 42 C.F.R. 422.503(b)(4)(vi)
- 423.504(b)(4)(vi)
- Section 50.3 of the Compliance Program Guidelines found in Ch. 9 of Medicare’s Prescription Drug Benefit Manual along with Ch. 21 in the Managed Care Manual.
Within 90 days upon employment and annually thereafter each employee is provided with the Code of Conduct (COC) to review and sign. Additionally, all current employees shall be provided with a copy of the COC upon request or when any changes are made.

The continued success of THP is dependent upon our customer’s trust. We are dedicated to preserving that trust through our employee’s actions to our customers and will always strive to act in a way that will merit the continued trust and confidence of the public.
As a part of the health care delivery system it is important that we always conduct ourselves in an ethical, legal and above-board manner. In addition to these high standards it is our job to commit fully to compliance and to be vigilant in the detection, prevention and correcting of fraud waste and abuse while administering benefits & services.

Each employees understanding of these commitments along with our willingness to raise ethical concerns are crucial to the well-being of our members and to the success of our business relationships.
MORE KEYS TO INTEGRITY

**Honesty** – Always act fairly and honestly with those who are affected by our actions. Always treat others as we would expect them to treat us if the situation were reversed.

**Compliance** – All persons should abide fully with federal and state rules, laws and regulations along with keeping the spirit of the law in your mind during all work activities.

Act in such a manner that the full disclosure of facts related to any activity you perform would reflect favorably upon both yourself and The Health Plan.

**Business Responsibility & You** – Always remember that what you do and what you say in the workplace should be aimed to enhance The Health Plan’s standing within our business community.
Responsibility for Reporting Violations

YOU are responsible for reporting suspected ethical violations. Because we promote a relationship built on mutual trust and respect we encourage professionals, employees, entities and vendors to ask any and all questions about a company practice without fear of adverse consequences.

What is an ethical violation?

- Violations (noncompliance) of law or policy
- Dishonest or unethical behavior which could result in harm
- Conflicts of interest
- Fraud waste or abuse
- Questionable accounting practices
- Suspicious or weak internal controls
**Fraud Waste and Abuse Correction and Detection**

YOU are responsible for recognizing any behavior that may lead to an adverse outcome if left uncorrected. Suspicious behavior should be reported at all times along with additional measures to ensure this behavior or action does not occur again in the future.

“What exactly am I reporting?”

If you are unsure about something, REPORT IT. Do not be concerned with the “fine print”. THP’s Compliance Department will investigate the issue and make the proper determination for you.

The Health Plan’s Code of Conduct & Fraud, Waste and Abuse training have been designed to provide practical guidance for all employees in the areas of compliance and FWA.
WHAT IS A CODE OF CONDUCT?

• A set of conventional principles and expectations that are considered binding on any person who is a member of that particular group.
• A set of rules that guide behavior, actions & 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 along with giving that company a positive public identity to which they associate themselves with.

Who must abide by the Code of Ethics?
• Board of Directors
• Executive Management Teams
• Directors, Supervisors and Managers
• Employees

*ALL Health Plan employees paid or unpaid must abide by the COC*
HOW DOES THE CODE OF CONDUCT AFFECT ME?

• Without knowing your COC you could unknowingly violate the regulations that are mandated by federal and state law such as submitting false, inaccurate or misleading information in a report.

• Employees must display good judgment while operating as an agent of The Health Plan, always considering the ethical implications of their business dealings and personal actions.

• Information you use for daily business can NOT be disclosed to unauthorized individuals for any reason.

• If I give or receive a gift related to marketing, education or other business activities I understand that it MUST be of modest monetary value & not be used as a way to persuade or bribe others to do business with THP.

Examples of COC violations

• An employee accepting a vendor’s bid over a competitor’s due to gifts given to the employee by said vendor.

• Employees providing a provider with gifts in return for referrals or beneficial arrangements to enroll more members with The Health Plan.

• Giving physicians, clients, members or potential members gifts above and beyond a reasonable monetary value for business gain that could put the company at risk for COC violations.
Employees must use caution when dealing with government officials as **NO funds** from The Health Plan can be used for illegal or improper activities such as:

- paying an official to secure a sale
- paying money to receive favorable treatment
- entertaining government officials or employees which could be seen as an attempt to influence the outcome of a business decision

**How can I exemplify my company’s COC?**
Always use GOOD judgment based on ethic principles with respect to lines of acceptable conduct! If situations arise where you are unsure of how to proceed due to a compliance or ethical dilemma, discuss your options with your immediate supervisor and if necessary the Personnel Department or Compliance officer.

**Who do I report my issue to?**
All employees will report suspicious activities & possible conflicts of interest of themselves and of others to The Health Plan’s Compliance Office:

**Tom Samol, 52160 National Road East, St. Clairsville OH 43950**

Fraud Hotline: 740.699.6111 or 877.296.7283

[healthplan.org](http://healthplan.org)
Compliance with this policy of business ethics and conduct is the responsibility of every Health Plan employee. Disregarding or failing to comply with this standard of business ethics and conduct could lead to disciplinary action up to and including possible termination. How can you avoid this?

• Be aware of the COC and understand how it might affect your job.
• Keep a copy of the COC available within your department to reference should an issue arise.
• Do not hesitate to report any suspected improper, unethical, or illegal activity to:
  • Immediate supervisors
  • Personnel Director
  • The Health Plan Corporate Compliance Officer Tom Samol (740.695.7638)
  • The Health Plan Hotline (1.877.296.7283)
  • healthplan.org

There can be NO retaliation against you for reporting a suspected issue in good faith.

“Ignorantia Juris Non Excusat”

Ignorance of the Law Does NOT Excuse!
THP adopts a progressive disciplinary policy which is located in the Employee Handbook. This policy means that with respect to most disciplinary problems the following steps will occur:

- **First Offense**: A verbal warning will be given.
- **Second Offense**: A written warning will be issued.
- **Third Offense**: The person will be suspended.

Any offense **AFTER** a third offense can result in termination. THP has the right to bypass any of these steps as deemed necessary.
An ongoing evaluation process is critical to ensure the noncompliance does not recur.

Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
Fraud, Waste and Abuse Detection & Prevention
Scams alone cost the healthcare industry more than $100 billion annually.

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

Detecting, correcting and preventing FWA requires collaboration between:
- You
- Providers of services such as physicians, nurses and pharmacies
- State and Federal Agencies
- Beneficiaries (Members/Enrollees)

Report to the Nation: Fraud and Abuse Facts for 2014

- Revenues the typical organization loses to fraud each year: 5%
- Small businesses bear the brunt of fraud losses disproportionately with a 28% higher median of fraud loses for an organization with less than 100 employees.

The full 2014 Report to the Nation can be found at http://www.acfe.com
DEFINITIONS

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

**Waste:** The over-utilization 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 following Federal and State employees are involved in the fight against fraud waste and abuse:

- The Office of Inspector General (OIG)
- Department of Health & Human Services
- Department of Justice (DOJ)
- Centers for Medicare & Medicaid (CMS)
- State Departments of Insurance
- Law Enforcement
- NBI Medic
- State Licensing Boards
WHAT: Fraud is when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself 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 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/procedures to maximize payments
• Billing for services not furnished and/or supplies not provided including billing MEDICARE 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
• I.E. ) Paying for a referral or patients in exchange for the ordering of diagnostic tests and other services or medical equipment.
• Unbundling or “exploding” charges
• Completing CMN’s for patients unknown by the provider and 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, descriptions of 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 individual’s Medicare Card to obtain medical care.
EXAMPLES OF MEMBER FRAUD

- Card Sharing or loaning/using another’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.

FRAUD WASTE & ABUSE HOTLINE
740.699.6111 OR 1.877.296.7283
WHAT IS ABUSE?

ABUSE describes a practice that either directly or indirectly results in unnecessary cost to any 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 the intent to defraud exists. However, abusive practices may under circumstances, 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
- Billing Medicare based on a higher fee schedule
- Submitting bills to Medicare when another carrier is primary
- Violating the participating provider agreement with Medicare & Medicaid
- Breaches in the assignment agreement
- Violating the maximum actual charge limit or the limitation amount when applicable.
It is important to know that…

According to the American Health Information Management Association (AHIMA) it is impossible to delineate between fraud and abuse on the basis of evaluating a single case or record.

In order to PROVE fraud, the Federal Government must prove the acts were performed knowingly, willfully and intentionally. To prove fraud occurred rather than abuse the upcoding or miscoding of an event must occur over time and across a large number of patients.

Examples:

A Florida Dermatologist was convicted of fraud because his practice billed for 3,086 false procedures over a period of 6 years.

A Medicaid provider and wife in Virginia were convicted of health care fraud for making false statements, alteration of records and two counts of identity theft with possible jail time of up to 10 years.
WHAT GOVERNS COMPLIANCE & FWA?

Social Security Act – Title 18

**Code of Federal Regulations** * - 42 CFR Parts 422 (Part C) and 423 (Part D)

**CMS Guidance** – Manuals & HPMS Memos

**CMS Contracts** – Private entities apply & contracts are renewed/ non-renewed each year

**State Laws** – Licensure, Financial Solvency, Sales Agents

**Other Sources** – OIG/DOJ (Fraud Waste and Abuse), HHS (HIPAA privacy)

- 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

**Our Responsibility to Correct**

Once fraud, waste or abuse has been detected it must be promptly corrected. Correcting the problems saves the government money and ensures you are in compliance with CMS requirements.

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer or your sponsor’s compliance officer to find out the process for the corrective action plan development.
THP’s Fraud, Waste & Abuse policy was established to identify and eliminate any fraudulent, wasteful or abusive uses of claims/services perpetrated by employees, members, participating/non-participating providers and facilities. Compliance with this policy is the responsibility of each and every Health Plan employee.

**How do we identify, report & prevent FWA?**

1. Anti-Fraud Policy Statement
2. Written Policies & Procedures
3. Formal Training
4. Fraud Hotlines
5. Education
6. Technology
7. Security
8. Patient Safety
Each department within THP is responsible for developing Fraud, Waste & Abuse policies and procedures to comply with established guidelines.

- The goal of these policies and procedures is to identify abusive or fraudulent acts
- Departments should create and maintain a list of potential issues they could face that are specific to each worker's job duties.
- This list should be included in your departmental policies.

**Formal Training**
Successful completion of the training is a condition of continued employment with THP. Per Health Plan policy, all employees must complete the company’s Fraud, Waste & Abuse training and successfully pass compliance training upon hire and annually thereafter.
Prohibits:
Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe or rebate) for referrals of services that are paid in whole or in part under a federal health care program, including Medicare. (42 United States Code §1320a-7b(b))

Penalties can include:
• Fines up to $25,000
• Imprisonment up to 5 years
• Both fines and imprisonment

Examples of Anti-Kickback Violations:
Pharmacies waiving Medicare co-payments in order to encourage enrollees to fill their prescriptions at that particular pharmacy.

Medicare Part D plan sponsor’s acceptance of a pharmaceutical manufacturer’s offer of a free disease management program in RETURN FOR encouraging Medicare enrollees to use the manufacturer’s products.

A drug manufacturer’s provision of a free trip to an employee of a Medicare Part D plan sponsor in return for the plan sponsor’s decision to place the manufacturer's drug in the preferred tier of the plan’s Medicare formulary.
FALSE CLAIMS

What is a false claim?

• Presenting a false claim for payment or approval
• Making or using a false record/statement in support of a false claim
• Conspiring to violate the False Claims Act
• Falsely certifying the type/amount of property to be used by the Government
• Certifying receipt of property without knowing if it is true
• Buying property from an unauthorized Government officer
• Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government
• 31 United States Code § 3729-3733

As an employee of The Health Plan you MUST:

• Ensure the integrity of the products & services provided along with all related submissions made to the government.
• Never falsify a document & knowingly submit misleading information.
• Take care and due diligence by verifying the accuracy of all data on which the certification is to be made.
• Take every submission of information to the government seriously & review the underlying requirements associated with certifications.
• Report any false, inaccurate or altered requests for payment of claims to The Health Plan’s Compliance Officer.
FALSE CLAIMS ACT (Qui tam) WHISTLEBLOWER
Under the False Claims Act a whistleblower is someone who reports to an employer, a regulatory body, or an oversight or review authority the violation of a regulation, standard or ethical obligation. Under the law there can be no retaliation to an employee who files a good faith report to their employer or government agency.

CIVIL FALSE CLAIMS ACT DAMAGES & PENALTIES
The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

STARK STATUTE (Physician Self-Referral Law)
Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn
- Medicare claims tainted by an arrangement that does not comply with Stark are not payable.
- Up to a $15,000 fine for each service provided.
- Up to a $100,000 fine for entering into an arrangement or scheme.
Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

**HIPAA Facts:**

- Safeguards to prevent unauthorized access to protected health care information.
- As an individual who has access to protected health care information, you are responsible for adhering to HIPAA.
- Covered entities and their business associates must assure the confidentiality, integrity, and availability of electronic protected health information.
As part of the annual contracting process with CMS, plan sponsors are required to attest that they (and their FDRs) will:

1. Restrict the use and disclosure of Medicare data obtained from CMS information systems to those purposes directly related to the administration of MA, MA-PD, Cost and/or PDP plan(s)

2. Only maintain data obtained from CMS information systems that is necessary to administer such plan(s)

3. Not re-use or provide other entities access to the CMS information systems, or data obtained from the systems, to support any line of business other than the MA, MA-PD, Cost and/or PDP plan(s)

4. Limit the use of information obtained from Medicare plan members to those purposes directly related to the administration of the plan(s)
FDR & HIPAA

All FDR’s must abide by THP’s Privacy Program policies or demonstrate that they have a dedicated Privacy Officer who is responsible for ensuring that all individuals within the respective delegated entity or vendor are trained on HIPAA regulations and the process for reporting privacy breaches.

The FDR’s Privacy Officer is also responsible for managing any issues related to privacy breaches and reporting to THP should a privacy breach occur that impacts Health Plan members or business.
EXCLUSIONS

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General

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

CRIMINAL FRAUD PENALITIES

• If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life.
• 18 United States Code §1347
Education is a top priority for The Health Plan. It is imperative that we educate enrollees about fraudulent & abusive practices through various means of communications listed below:

- Member Newsletters
- Member Handbook
- The Health Plan website located at healthplan.org

Using a variety of software & technology to analyze claims, The Health Plan is able to process & adjudicate claims in a timely & efficient manner. The claims processing software also allows for retrospective review of claims, trending, and outlier identification. Through claims analysis The Health Plan is able to identify potential abusive and/or fraudulent claim activity from either providers and/or members.
**Security:**
The Health Plan has established various system safeguards to protect claim, member and provider information.

As a Health Plan employee, it is YOUR RESPONSIBILITY to protect your computer passwords and workstations. It is also your responsibility to maintain confidentiality and uphold The Health Plan’s Code of Conduct and all applicable HIPAA laws and regulations.

**Safety:**
Because some fraud and abuse issues can turn into potential patient safety issues, it is important to educate Health Plan Members. Below are examples of such instances:

- Pharmaceuticals
- Altered prescriptions
- Illegal refills
- Prescription splitting
- Abuse of controlled substances
- Medical errors, both inpatient & outpatient
- Improper settings for procedures & services that may result in poor outcomes.
1. To report a suspect incident in good faith, please complete the internet form found by clicking on the orange link labeled “Report Fraud”. This button is found at the bottom right of every page on our website and allows online access to the Fraud Suspect Activity Form/Reporting Mechanism.

2. You may also call THP’s Fraud Hotline at 1.740.699.6111 or 1.877.296.7283.

3. If you would like to speak to the compliance officer you may reach Tom Samol at 740.695.7638.

To report anonymously please use the form on healthplan.org or call 1.877.296.7283
In accordance with the False Claims Act and other federal laws and regulations, THP has a strict no-tolerance policy for retaliation and retribution against any employee who reports suspected fraud, waste and abuse.

If you suspect any of the above, report it immediately!

As a Health Plan employee it is your duty to be vigilant in the fight against fraud waste and abuse.
Compliance with The Health Plan’s Code of Conduct & Fraud, Waste and Abuse policies are the responsibility of each and every Health Plan employee.

Each department has established policies outlining specific risk areas and responsibilities; as well as ensuring that each employee understands their various departmental policies.

If you are unsure about a policy or if you suspect fraud waste or abuse please contact your immediate supervisor, department manager or The Health Plan’s Compliance Officer Tom Samol located at the St. Clairsville office. (740.695.7638)

Reminder:
The Corporate Compliance Plan is located on the internet & intranet. Please take time to review this document as it is the foundation for our dedication to The Health Plan’s compliance culture.
Government Resources

1. National Benefit Integrity MEDIC: http://www.healthintegrity.org/index.html
2. Stop Medicare Fraud: http://www.stopmedicarefraud.gov
7. Fraud Alerts, Bulletins and Other Guidance from the OIG: http://oig.hhs.gov/compliance/alerts/index.asp
10. Anti-Kickback Statute (see section 1128B(b)): http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f
RESOURCES

12. TRICARE Fraud & Abuse: http://www.tricare.osd.mil/fraud

Other Resources:
2. Heath Care Compliance Association (HCCA): http://www.hcca-info.org
6. Institute for Health Care Improvement (IHI): http://ihi.org

Links to OIG and GSA Exclusions Databases
• OIG LISTSERV via the OIG Website: http://exclusions.oig.hhs.gov/
• General Services Administration (GSA) database of excluded individuals/entities: https://www.epls.gov/
To ask any further questions not addressed within this training please contact:

**Tom Samol**  
Compliance Officer  
740.695.7638 • tsamol@healthplan.org

**Vicki Pennybacker**  
Compliance Department, Manager of Compliance & Auditing  
740.695.7622 • vickip@healthplan.org

**Michelle Durdines**  
SIU Manager  
740.695.7665 • michelled@healthplan.org