Compliance and Fraud, Waste and Abuse

Prevention Training for FDRs, Subcontractors and Contracted Providers

TheHealthPlan

healthplan.org

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FDR and Subcontractor Definitions

FDR means First Tier, Downstream or Related Entity. FDRs include delegates, agents and other individual entities such as vendors contracted with THP to provide administrative and/or health care services for its Medicare Advantage line of business.

Subcontractor means a party contracting with the managed care organization (MCO) to perform services related to the requirements of the contract between the MCO and the West Virginia Bureau for Medical Services (BMS) or the West Virginia Children's Health Insurance Program (WVCHIP). Subcontractors may include affiliates, subsidiaries and affiliated and unaffiliated third parties. Subcontractors do not include vendors contracted for the provision of utilities, mail/shipping, office space or computer hardware.

THP expects its FDRs, Subcontractors and contracted providers to operate in accordance with all applicable federal and state laws, regulations and Medicare and Medicaid program requirements.

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

THP's Compliance Program

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 it delegates to its FDRs. As such, THP conducts regular auditing and monitoring of these entities.

West Virginia Mountain Health Trust (MHT) oversees West Virginia Medicaid and WVCHIP:

- The Health Plan must have internal controls, policies and procedures to prevent and detect noncompliance and FWA.
- 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. We must commit fully to compliance and be vigilant in the detection, prevention and correction of noncompliance and FWA while administering health care benefits and services.

If you are a provider of health care services to Medicare, West Virginia Medicaid and/or WVCHIP beneficiaries, you should have a compliance program that is based upon 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, FDRs/Subcontractors and contracted providers 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 and a positive public image.

All FDRs, Subcontractors and contracted providers of The Health Plan should adhere to our code of conduct or their own comparable standards of conduct. The Health Plan's code of conduct can be accessed through the following link:

Access THP's Code of Conduct here.

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 your employees through the Office of Inspector General (OIG) List of Excluded Individuals and Entities and the Government Services Administration System for Award Management (GSA or SAM). You should conduct these screenings at hire and each month thereafter. You should also maintain records of these screenings for at least 10 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://sam.gov/content/home

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 D-SNP members, you are required to complete The Health Plan's Medicare Advantage D-SNP Training on an annual basis.

THP Medicare Advantage SNP training can be accessed at:

https://www.healthplan.org/application/files/6416/1608/5038/DSNP_Provider_MOC_2021_Training_Presentation.pdf

Steps to Promote Compliance

Monitor Your Processes (FDRs and Subcontractors)

If you are an FDR or Subcontractor, the 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 for which you are delegated such as:

- **Appeals and Grievances:** Appeals and grievances must be processed within the guidelines published by Medicare and/or MHT. Appeals and grievances must be processed timely and member notification letters must include the required elements.
- **Call Monitoring:** Call centers must be monitored to ensure all applicable guidelines are met including answering member calls within 30 seconds and maintaining a call abandonment rate of less than five percent. Make sure you understand the call center requirements applicable to the delegated duties, whether issued by MHT, Medicare or both.
- **Contracts and Business Owners:** Ensure you understand the requirements in your contract with The Health Plan. Be sure to stay in regular contact with the applicable business owners at The Health Plan and cooperate with all monitoring activities initiated by these staff members.

Steps to Promote Compliance

Monitor Your Processes (contracted providers)

If you are a provider of healthcare services, the 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 provided. CPT and diagnosis codes change annually. You should use certified coders to make sure your claims are correct. Not only will this keep you out of trouble with federal regulators, but the submission of 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.

Reporting FWA and Noncompliance

Responsibility for Reporting Violations

As part of The Health Plan's commitment to compliance, our FDRs and Subcontractors 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's government compliance officer, Jill Medley or the compliance department (1.800.624.6961, ext. 7693)
- Call The Health Plan's Hotline (1.877.296.7283) (allows anonymous reporting)
- Email the Compliance Department at compliance@healthplan.org (noncompliance) or SIU Department siu@healthplan.org (FWA)
- Report through The Health Plan's website by using the "Report Fraud" link: https://www.healthplan.org/report-healthcare-fraud

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

Compliance Program Review

The Health Plan's compliance department may audit your compliance program:

In accordance with state and federal guidelines, THP's compliance department conducts audits on its FDRs and Subcontractors, including reviews of their compliance program effectiveness and their HIPAA privacy and security practices.

These audits may be conducted on site or as a desk audit. During these audits, THP's compliance department will request policies, procedures, employee information (screenings and trainings) and if applicable, the FDR's/Subcontractor's HITRUST or SOC audit reports.

Once the audit is complete, THP will provide an audit report to the FDR/Subcontractor which includes any findings or recommendations.

Fraud, Waste and Abuse (FWA) Detection and Prevention

Why Focus on FWA?

Fraud Statistics

Healthcare scams cost the healthcare industry more than $80 billion annually (Coalition Against Insurance Fraud estimate).

Medicare fraud is estimated to cost $60 billion every year (AARP 2018).

The FBI estimates non-medical insurance fraud to be at least $40 billion every year.

FWA prevention programs save Medicare and Medicaid dollars and benefit taxpayers, the government, health plans and beneficiaries.

Why Focus on FWA?

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 detection
- Drug diversion costs individual private insurers up to $857 million annually

FWA Definitions

Fraud is knowingly submitting or causing to be submitted false claims and/or the misrepresentation of facts to obtain a benefit. Fraud also includes knowingly soliciting, receiving, offering or paying kickbacks or bribes to induce referrals and/or making prohibited referrals for certain designated health services.

Waste is the overutilization of services or other practices that result in unnecessary costs. Waste is characterized by a misuse of resources, rather than an intentional act or blatant disregard for the rules.

Abuse includes actions that are inconsistent with accepted and sound medical practices, such as those that provide patients with medically unnecessary services or services that do not meet accepted standards of care. Abuse results in unnecessary costs to federal healthcare programs.

More About Fraud and Abuse

Abuse describes a practice that either directly or indirectly results in unnecessary costs 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 knowingly and willfully participated in 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

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, or cause a claim to be filed, for Medicare or Medicaid payment

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 partners. Seldom will perpetrators target only one insurer or the public or private sector exclusively.
Most schemes defraud both sectors with no specificity, including both Medicare and Medicaid.

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Examples of Provider 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 multiple 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

Examples of Member Fraud

- Card sharing or loaning/using another person's insurance card
- Obtaining prescriptions under false pretenses
- 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

Reporting Fraud, Waste and Abuse

To report a suspect incident, complete The Health Plan website form found by clicking on the green button labeled **"Report Healthcare Fraud"**. This button is found at the bottom right of every page on The Health Plan's 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** or **SIU@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.

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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" protections and steep penalties for violations.

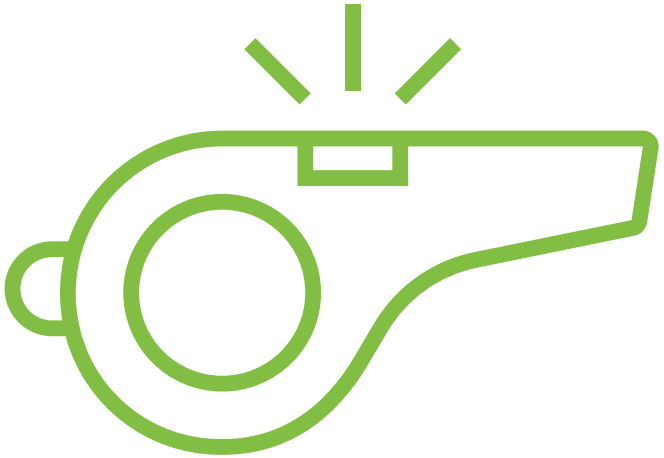
Examples of Potential False Claims

- 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 for each false claim. 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 can 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 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.

Health Care Fraud

18 U.S.C § 1347 makes it a crime to knowingly and willfully execute or attempt to execute a scheme to defraud any health care benefit program or to obtain by false or fraudulent pretenses, money or property of any health care benefit program, in connection with the delivery of, or payment for, health care benefits, items, or services.

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 covered entities to protect the privacy of their patients' health care information. This information is called protected health information or PHI.

The **HIPAA Security Rule** requires covered entities to implement administrative, physical and technical safeguards to protect electronic PHI (ePHI). In addition, covered entities 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 covered entities to 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 if 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 regard to their PHI. Patients have the right to:

Receive a Notice of Privacy Practices: This notice explains how the individual's PHI will be used and disclosed. Covered entities are required by law to provide this notice (NPP) to individuals. 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 covered entity cannot deny access because a patient has not paid for health care services. Covered entities may charge a reasonable cost-based fee for providing copies to the patient, but covered entities 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 covered entities 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 covered entities 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 covered entities 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 the covered entity has violated their HIPAA rights.

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More Information

More Information

You can get more information through the following documents:

- The Health Plan's FDR and Subcontractor Standards of Conduct
- Medicare Managed Care Manual – Compliance Program Guidelines
- OIG Compliance Program Guidance for Individual and Small Group Physician Practices
- OIG Compliance Program Guidance for Medicare+Choice Organizations
- OIG Compliance Program Guidance for Third-Party Medical Billing Companies
- OIG Provider Compliance Training Videos
- A Roadmap for New Physicians – Avoiding Medicare and Medicaid Fraud and Abuse