Provider Network Update

Provider Compliance Training

An Overview of FWA, Compliance, and Privacy Laws

Presented by: Program Integrity, Special Investigations Unit, and Compliance

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Disclaimer:

The information in this presentation is not intended to constitute legal advice.

This presentation includes information relating to general compliance requirements for mental health and substance use providers serving Medicaid patients but is not meant to be considered all-inclusive as there are other applicable laws and regulations not cited.

Providers are responsible for complying with all federal and state laws, regulations, and guidance pertaining to the Medicaid program and should always validate that the materials being referenced include the most up-to-date content.

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Agenda

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- Defining Fraud, Waste, and Abuse (FWA)
- An Overview of Pennsylvania and Federal Compliance Laws
- Your Role as a Provider in Identifying and Reporting Fraud and Abuse
- Examples Of Medicaid Fraud and Abuse
- The Role of the Special Investigations Unit (SIU)
- Preventing, Detecting, and Reporting Fraud and Abuse
- Elements of an Effective Compliance Program
- Health Insurance Portability and Accountability Act (HIPAA) and Other Privacy Laws

What are Fraud, Waste, and Abuse (FWA)?

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- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.[1]

- **Waste** includes incurring unnecessary costs as a result of deficient management, practices or controls.[2]

- **Abuse** means provider practices that are inconsistent with sound fiscal, business or medical practices that result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.[3]

1. Source: 42 CFR § 455.2
2. Source: https://oig.hhs.gov/compliance/physician-education/roadmap_speaker_notes.pdf
3. 42 CFR § 455.2

Federal and Pennsylvania Laws & Regulations

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Federal Laws Governing General Compliance and the Sharing of Patient Information

- The Federal False Claims Act (FCA)
- The Fraud Enforcement and Recovery Act (FERA) and Deficit Reduction Act (DRA)
- The Anti-Kickback Statute
- The Physician Self-Referral Statute (Stark Law)
- The Health Insurance Portability and Accountability Act (HIPAA)
- 42 CFR Part 2: Substance Abuse and Confidentiality

State Laws Governing Compliance and the Sharing of Patient Information

- 4 PA Code § 255.5: Disclosure of Client-oriented Information
- PA Mental Health Procedures Act

Federal Compliance Laws & Regulations

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Federal False Claims Act (FCA) – The FCA applies to fraud involving any federally funded contract or program. Any individual/entity that knowingly submits a false claim to the government is subject to civil penalties that may include treble damages.

Fraud Enforcement and Recovery Act (FERA) – This act increases the scope of liability of the FCA to include an individual/entity that knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.

Deficit Reduction Act (DRA) – The DRA requires all entities receiving $5 Million or more in annual Medicaid payments to establish policies relating to: the FCA and administrative remedies for false claims, the prevention and detection of FWA, and detailed information on whistleblower protections.

Anti-Kickback Statute – This law prohibits someone from knowingly or willfully offering, paying, seeking, or receiving anything of value in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program. Violations are punishable by criminal sanctions including imprisonment and civil monetary penalties.

Physician Self-Referral Statue (Stark Law) – This law prohibits physicians from referring Medicaid & Medicare patients to an entity in which the physician (or immediate family) has a financial relationship. Violations are punishable by a civil penalty up to $15,000 per improper claim, denial of payment, and refunds for certain past claims.

What is my role as a Provider for FWA reporting?

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As a Provider, you can prevent, detect, and report FWA in the following ways:

- If you suspect or detect fraud, you should report it immediately to the PerformCare Special Investigation Unit (SIU). Additional details on your duty to report and the way in which reports can be made can be found in the PreformCare Provider Manual.
- You should ensure that you are only billing for the services that you have provided.
- You should review and understand your roles and responsibilities as a network Provider. You should contact your PerformCare Account Executive with any questions or concerns.
- You should review and understand the applicable licensure responsibilities and restrictions.
- You should monitor medical records to ensure documentation supports the services rendered.
- You should take immediate action if you identify an internal problem and report it as necessary.
- You should establish effective lines of communication.
- You should practice self-disclosure.
- You should stay educated on fraud, waste, and abuse best practices.

Examples of Fraud or Abuse

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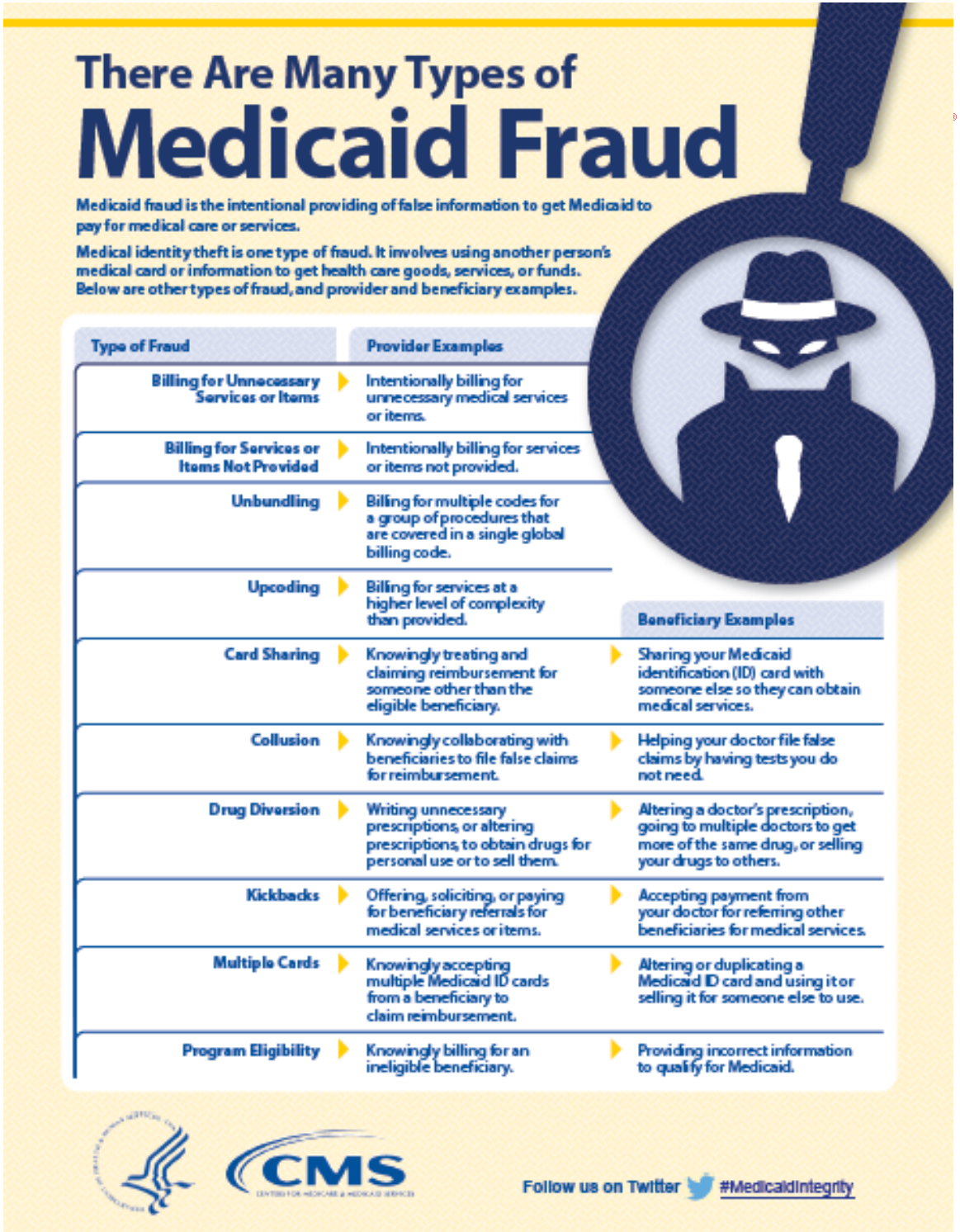
- A Provider billing for services not provided or rendered.
- A Member using someone else's insurance card to receive care.
- The unbundling of a comprehensive service into individual components for billing purposes in order to receive higher reimbursement.
- A Provider billing or charging Medicaid recipients for covered services.
- A Provider billing more than once for covered services.
- A Provider dispensing generic drugs and billing for brand name drugs.
- A Provider falsifying or back dating clinical records or entries.
- A Provider performing inappropriate or unnecessary services.
- A Provider failing to complete necessary clinical medical record documentation.
- A Provider failing to adhere to appropriate documentation standards for service provisions relating to the level of care.

CMS Examples of Fraud

- Billing for Unnecessary Services
- Billing for Services Not Provided
- Unbundling
- Upcoding
- Card Sharing
- Collusion
- Drug Diversion
- Kickbacks
- Multiple Cards
- Program Eligibility



Federal Fraud and Abuse Enforcement

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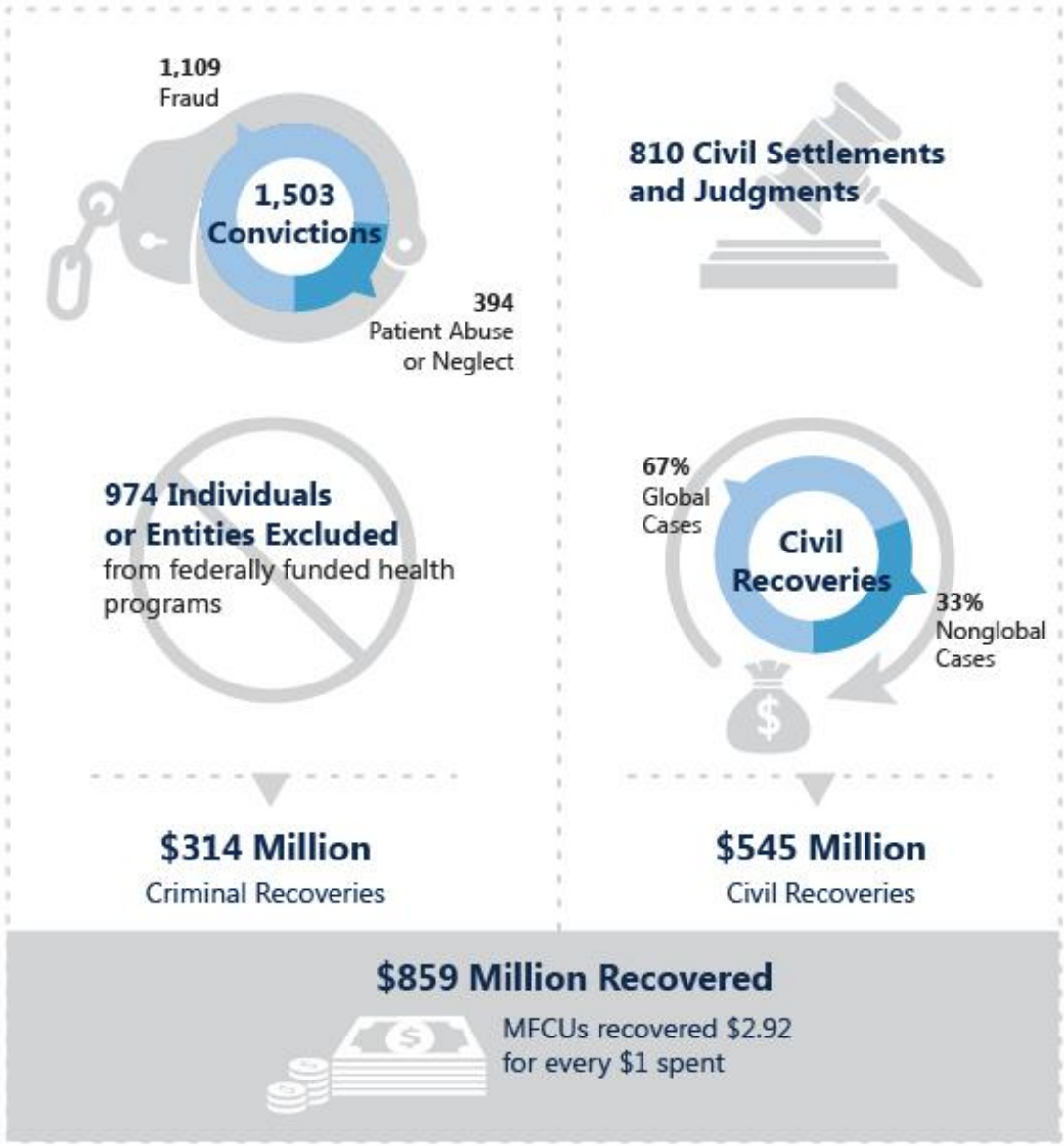

- In fiscal year 2018, the Federal Medicaid Fraud Control Unit (MFCU) cases resulted in 1,503 convictions. This total included 1,109 convictions for fraud and 394 convictions for patient abuse or neglect.
- For fiscal year 2018, the MFCU reported criminal recoveries in the amount of $314 million and civil recoveries of $545 million.

Fraud and Abuse Enforcement in Pennsylvania

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- During the 2018 fiscal year, the Pennsylvania Medicaid Fraud Control Unit (MFCU) reported 164 arrests, 105 convictions, and total recoveries of over $22 million.

- In fiscal year 2018, the MFCU in conjunction with the Office of Inspector General charged 15 individuals involving nearly $237,000 in fraudulent payments. The charges involved a range of providers—personal care attendants, behavioral health providers, and Medicaid case managers.

- As per Appendix F of the HealthChoices Program Standards and Requirements, the SIU is to report any concerns related to potential fraud to the MFCU. In one referral, the MFCU found evidence of double billing with different Members and forgery of parent signatures by a Behavioral Specialist Consultant and criminal charges were filed.

- The Federal Civil Monetary Penalties law allows for penalties between $10,000 and $50,000 and up to three times the amount unlawfully claimed for FWA violations.

Fraud and Abuse in the Headlines

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May 9, 2018 – Nurse Sentenced for Health Care Fraud Related Charges for False Billing

- MOUNT CARMEL, PA – The owner and operator of Twilight Beginnings, a provider of mental health services, used her company to recruit individuals who were either not properly licensed or unlicensed and have them "provide" psychiatric care to patients.
- The owner, a Pennsylvania licensed Certified Registered Nurse Practitioner and Registered Nurse, was sentenced to 72 months' imprisonment and three years of supervised release.

March 25, 2019 - Two Individuals Charged in Health Care Fraud Scheme Involving Drug and Alcohol Rehabilitation Center with Multiple Pennsylvania Locations.

- PHILADELPHIA, PA – First Assistant United States Attorney announced the filing of federal charges in connection with a health care fraud scheme involving Liberation Way, a drug and alcohol rehabilitation organization that had treatment centers in Yardley, Bala Cynwyd, and Fort Washington, Pennsylvania. The defendants are each charged with one count of conspiracy to commit health care fraud.
- If convicted, each defendant faces a maximum possible sentence of five years' imprisonment and a fine of $250,000, along with restitution of millions to the victims of this fraud.

May 15, 2019 - Owner of Opioid Addiction Treatment Practice with Offices in Western PA and West Virginia Pleads Guilty to Illegal Distribution and Health Care Fraud

- PITTSBURGH, PA – A resident of Washington, PA, pleaded guilty in federal court to charges of aiding and abetting the unlawful distribution of controlled substances and health care fraud.
- The law provides for a total sentence of 30 years in prison, a fine of $1,250,000, or both. Under the Federal Sentencing Guidelines, the actual sentence imposed is based upon the seriousness of the offenses and the prior criminal history, if any, of the defendant.

Role of the PerformCare SIU

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Intake

- Compliance Hotline
- SIU Fraud Tip email
- Member Service Verification Letters
- External/Internal Referrals

Investigation

- Preliminary Screening
- Data Collection
- Data Analysis
- Clinical Review
  - Post-pay Review
  - Pre-pay Review
- Findings
- Overpayments
- Provider Education

Referrals

- Office of Inspector General: Medicaid Fraud Control Unit
- Office of Attorney General
- Department of Human Services, Bureau of Program Integrity (BPI)
- Local Law Enforcement

Special Investigations Unit (SIU) Requests

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Record Request Letter (30 days from the date of the letter to respond to the request)

- List of Member(s) records requested for a specific time frame and level of care
- Due date for the submission of Member records and/or related provider documentation, such as staff case load, organizational chart, etc.
- Clinical Investigator's name and contact information

Second Record Request Letter (15 days from the date of the letter to respond to the request)

- Copy of Initial Request Notification letter
- Revised record submission due date
- Consequences of noncompliance

Overpayment Findings Letter

- List of violations and corresponding citations for the Provider's education and research
- Detailed audit spreadsheet with overpayment amounts outlined
- Date overpayment check is to be sent to PerformCare if Provider is in agreement with the findings
- Details on when and how a Provider may file a dispute if they disagree with the findings
- Details for Provider Education to be coordinated by Provider Relations
- If applicable, request for Quality Improvement Plan (QIP) with due date

PerformCare SIU Monitoring Activities

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- Per Appendix F of the HealthChoices Behavioral Health Program Standards and Requirements and federal CMS regulation, PerformCare is required to monitor its provider network and report any suspected fraud, waste, or abuse.
- SIU monitors claims for accuracy and ensures that the coding reflects the services that were provided.
- SIU audits medical records to ensure the documentation supports the services rendered.
- SIU establishes effective lines of communication.
- SIU will investigate and take appropriate action as needed, including:
  - Referral to PerformCare Quality Improvement department
  - Referral to PerformCare Credentialing Department
  - Referral to DHS Bureau of Program Integrity (BPI)
  - Referral to Office of Attorney General Medicaid Fraud Control Unit (OAG/MFCU)

How to Report Fraud, Waste, and Abuse

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PerformCare FWA Reporting Contacts:

SIU Manager: Erin O'Connor-Pritchard
Email: epritchard@performcare.org
Phone: 717-671-6554

Fraud Tip Hotline: 1-866-833-9718

Email: FraudTip@amerihealthcaritas.com

Mail:
PerformCare SIU
8040 Carlson Road
Harrisburg, PA 17112

PA Medical Assistance FWA Reporting:

BPI Fraud Hotline: 1-844-347-8477

MA Provider Compliance Hotline:
1-866-379-8477

Online:
http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm

Mail:
Department of Human Services
Office of Administration
Bureau of Program Integrity
P. O. Box 2675
Harrisburg, PA 17105-2675

Office of Inspector General Recommended Elements of an Effective Compliance Program

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What is Compliance?

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As a part of the community that serves Medicaid enrollees, it is important that you conduct yourself in an ethical and legal manner.

It's about doing the right thing in the right way!

Act fairly and honestly

Adhere to high ethical standards in all that you do

Comply with the letter and spirit of the law

Report suspected violations

The 7 Elements of an Effective Compliance Program

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The 7 Compliance Program Requirements as Adopted by the OIG and CMS

The PA HealthChoices Agreement requires all MCOs and Providers to maintain a compliance program. The 7 required elements are listed below:

1. Written Policies, Procedures, and Standards of Conduct
2. Designation of a Compliance Officer and Compliance Committee
3. Effective Compliance Training and Education
4. Effective Lines of Communication Between the Compliance Officer, Board, Executive Management and Staff (Including an Anonymous Reporting Function)
5. Enforcement Standards and Disciplinary Guidelines
6. Provisions for Internal Monitoring and Auditing
7. Mechanisms for Responding to Detected Problems and Development of Corrective Action initiates.

The PA HealthChoices "8th Element"

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Demonstration of Overall Compliance Plan Effectiveness

- The MCO and Provider must be able to show evidence that their Compliance Program is more than just words on a piece of paper and there is active oversight of the program.

- The MCO and Provider must be able to show evidence of an effective program with a proactive approach to the identification of fraud, waste, and abuse. Ensure that procedures are in place to identify and report suspected FWA to the proper channels.

- Self-auditing is an excellent tool to demonstrate compliance program effectiveness and to identify and remediate any issues that are found.

What is my role as a Provider in Compliance?

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Corporate Compliance Activities and Self-Audit

- Providers are required to ensure they are in compliance with all Medicaid billing protocols.
- PerformCare requires its Providers to periodically conduct self-audits to ensure compliance with Medicaid regulations and to have a mechanism to self-report instances of potential fraud or abuse to PerformCare within 72 hours of the finding.
- The Department of Human Services issued MA Bulletin 99-02-13 “The Bureau of Program Integrity and the Medical Assistance Provider Self-Audit Protocol.” This document has helpful information and guidance.
- All Providers are expected to follow all applicable rules and regulations, this includes not only Medicaid regulations but also OMHSAS and BDAP Bulletins.
- All Providers are subject to the provisions of the Pennsylvania Medical Assistance Manual Chapter 1101 and Chapter 1150. Additionally, there are chapters for most services reimbursed under the Pennsylvania Medical Assistance Program including, Drug and Alcohol Outpatient, Mental Health Outpatient, Inpatient and more.

What is Noncompliance?

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Noncompliance is conduct that does not conform to the rules and regulations applicable to state and federal health care program requirements, or to the organization's standards of conduct or policies and procedures.

How Noncompliance Harms Members

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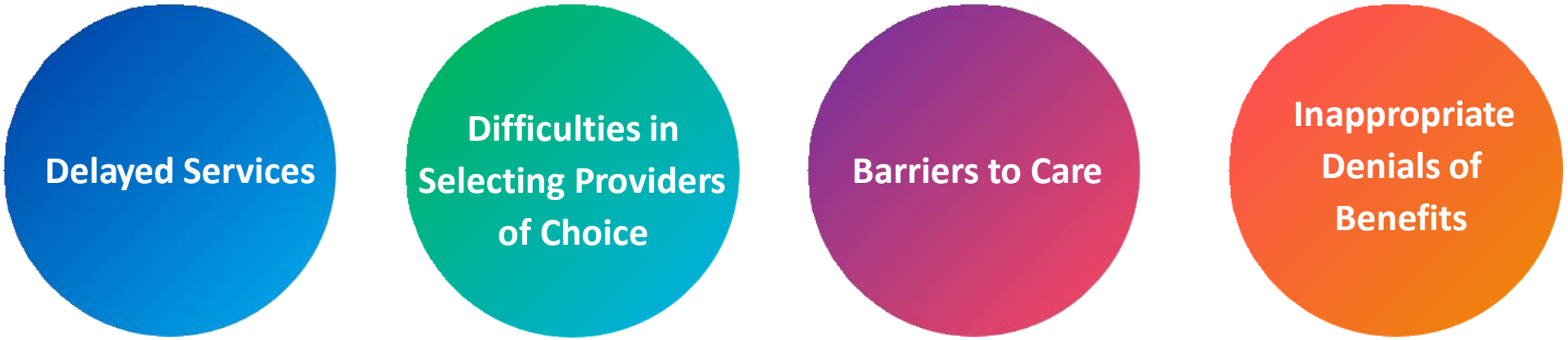
Without effective programs to prevent, detect, and correct noncompliance, there can be the following consequences for Members:



How to Report Issues of Noncompliance

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PerformCare Compliance

Any Provider may bring a concern directly to the PerformCare Compliance Officer in the following ways:

Mail:

PerformCare Compliance
8040 Carlson Road
Harrisburg, PA 17112

Toll-free Anonymous Hotline: 1-800-575-0417

Email: CorpCompliance@amerihealthcaritas.com

Additional questions can be directed to:

Leslie Marshall, Compliance Director
(717) 540-1146 or lpmarshall@performcare.org

Please remember all reporting will remain confidential. Reporting by use of the toll-free hotline will allow the individual to remain anonymous. However, there may be instances that require further involvement or information from the reporting individual during the investigation.

HIPAA and Other Privacy Laws

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HIPAA and HITECH

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- The **Health Insurance Portability and Accountability Act (HIPAA)** is a federal law passed in 1996 due to the rapid growth of health information systems and the need to safeguard individuals' health information.
- The **Health Information Technology for Economic and Clinical Health Act (HITECH)** was enacted, in part, as part of the American Recovery and Reinvestment Act of 2009 to encourage the adoption and "meaningful use" of electronic health records.
- The **HIPAA Omnibus Rule**, promulgated and finalized in 2013, is a set of regulations that modified HIPAA's Privacy, Security, and Enforcement Rules to implement various provisions of the HITECH Act.

The Privacy Rule

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The HIPAA Privacy Rule is a set of national standards for the protection of certain health information.

The HIPAA Privacy Rule applies to all covered entities and their business associates.

- **Covered Entity** — A health care provider, health plan or health care clearinghouse that electronically transmits and receives protected health information (PHI).

- **Business Associate** — An entity or person who performs services or functions for a covered entity. The Privacy Rule allows a covered entity to share PHI with its business associates. However, a covered entity must have a contract that prohibits these business associates from using or disclosing PHI in any way that would violate the Privacy Rule.

Protected Health Information (PHI)

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The HIPAA Privacy Rule protects the privacy and confidentiality of information known as protected health information, commonly referred to as PHI.

Protected Health Information (PHI) is individually identifiable health information that is:

- Transmitted or maintained in electronic media.
- Transmitted or maintained in any other form including print, voicemail, etc.

To be considered PHI, the information must have two components:

- **Medical Information** — Information about an individual's past, present or future physical or mental health care received, or health care payment information.

- **Personally Identifiable Information (PII)** — Data elements that can identify or can reasonably lead to the identification of an individual.

HIPAA Breach Notification Rule

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Breach — An unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA.

The Breach Notification Rule requires covered entities to notify affected individuals, the U.S. Department of Health and Human Services and, in some cases, the media, of a breach of unsecured PHI.

- The U.S. Department of Health and Human Services requires health care companies to submit a log of all breaches involving fewer than 500 individuals once a year, no later than 60 days after the end of the calendar year.
- For a breach that involves 500 or more individuals, health care companies must notify the U.S. Department of Health and Human Services no later than 60 days from the time of discovery.

Member PHI Use and Disclosure

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The Privacy Rule defines and limits the circumstances when PHI may be used and disclosed.

HIPAA Privacy regulations allow covered entities to use or disclose PHI without a member's permission for certain limited purposes. These exceptions are for the *treatment* of members, the *payment* of providers, and for health care *operations*. These are commonly referred to as TPO exceptions.

In addition to the TPO exceptions, there are very specific occasions when a covered entity can disclose PHI without a member's consent. These permitted disclosures can include but are not limited to:

- If required by law or law enforcement.
- For public health purposes.
- To report abuse.
- To avert a serious threat.

Minimum Necessary Rule — Restricts the use and disclosure of PHI to only the amount necessary to perform a specific task.

HIPAA Civil and Criminal Fines and Penalties

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Civil Penalties:

- Range from $100 to $50,000 per violation, with a maximum penalty of $1.5 million per year for violations of an identical provision.

Criminal Penalties:

- Covered entities and specified individuals who knowingly obtain or disclose PHI in violation of HIPAA may be fined up to $50,000 and one year of imprisonment.
- Offenses committed under false pretenses may be fined up to $100,000 and up to five years of imprisonment.
- Offenses committed with the intent to sell, transfer or use PHI for commercial advantage, personal gain or malicious harm may be fined up to $250,000 and up to 10 years of imprisonment.

Substance Abuse and Confidentiality - 42 CFR Part 2

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42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, treatment, or prevention of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Written Consent Required

- Information can be shared if written consent is obtained.

Mandatory Disclosures

- 42 CFR Part 2 allows for disclosure where:
  - the state mandates child-abuse and neglect reporting;
  - when cause of death is being reported; or
  - with the existence of a valid court order.

Permitted Disclosures

- Programs are permitted to disclose patient-identifying information in cases of:
  - medical emergency;
  - in reporting crimes that occur on program premises or against staff;
  - to entities having administrative control;
  - to qualified service organizations; and
  - to outside auditors, evaluators, central registries, and researchers.

4 PA Code Section 255.5

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§ 255.5 - Projects and Coordinating Bodies: Disclosure of Client-oriented Information

- A "project" may only disclose drug and alcohol treatment information to a MCO with the patient's written consent.***

- **Project** – The public or private organization responsible for the administration and delivery of drug or alcohol services, or both, through one or more facilities. A project is a component of an SCA drug and alcohol program. (28 Pa. Code § 701.1)

- Please note the restrictions of this section apply to the disclosure of information from licensed treatment providers to MCOs, other third party payers, government officials, judges and probation/parole officers.

***In emergency medical situations where the life of the client is in immediate jeopardy, projects may release client records without the consent of the client to proper medical authorities solely for the purpose of providing medical treatment to the client.

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Citations Page

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- The Federal False Claims Act (FCA): 31 US Code §§ 3729 – 3733
- The Fraud Enforcement and Recovery Act of 2009 (FERA)
- Deficit Reduction Act of 2005 (DRA):
- The Anti-Kickback Statute:
- The Physician Self-Referral Statute (Stark Law): 42 US Code § 1395nn
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Substance Abuse and Confidentiality: 42 CFR Part 2
- Disclosure of Client-oriented Information: 4 PA Code § 255.5
- PA Mental Health Procedures Act: Title 50 P.S. § 7101
- Antikickback Statute: 42 U.S.C. § 1320a-7b(b)
- Office of Inspector General Compliance Guidelines:

  https://oig.hhs.gov/compliance/compliance-guidance/index.asp

Questions?

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More than

20 YEARS

of making

care the **heart**

of our **work.**

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