Provider Fraud, Waste, & Abuse Training

Spring 2022

Disclaimer

The information provided in this presentation outlines the requirements for claims billing audits completed by Highmark Wholecare's Fraud, Waste, & Abuse Team.

Providers may also be required to complete other audits by Highmark Wholecare or State & Federal oversight agencies as a requirement of their participation in Federal & State healthcare programs.

Please consult your provider manual & the appropriate Federal & State regulatory agency websites for further information.

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Fraud, Waste, & Abuse (“FWA”) Overview

- Overview of FWA
- Laws & Regulations
- Provider Responsibilities
- Documentation Requirements
- Types of Investigations
- Outcomes for Noncompliance
- Resources & Websites

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Overview of Fraud, Waste, & Abuse ("FWA")

- Definitions of FWA
- FWA Mission
- Functional Areas
- FWA Functions
- Red Flags of Fraud

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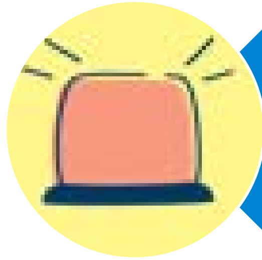
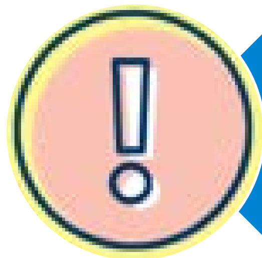
What is Fraud, Waste, & Abuse (“FWA”)?



FRAUD

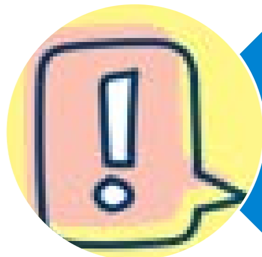
Knowingly & willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

In other words, fraud is intentionally submitting false information to the government or a government contractor to get money or a benefit.



WASTE

Practices that, directly or indirectly, result in unnecessary costs to the Medicare or Medicaid Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the **misuse of resources**.



ABUSE

Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, & the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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Examples of Fraud, Waste, & Abuse (“FWA”)

Fraud

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment

Waste

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory

Abuse

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

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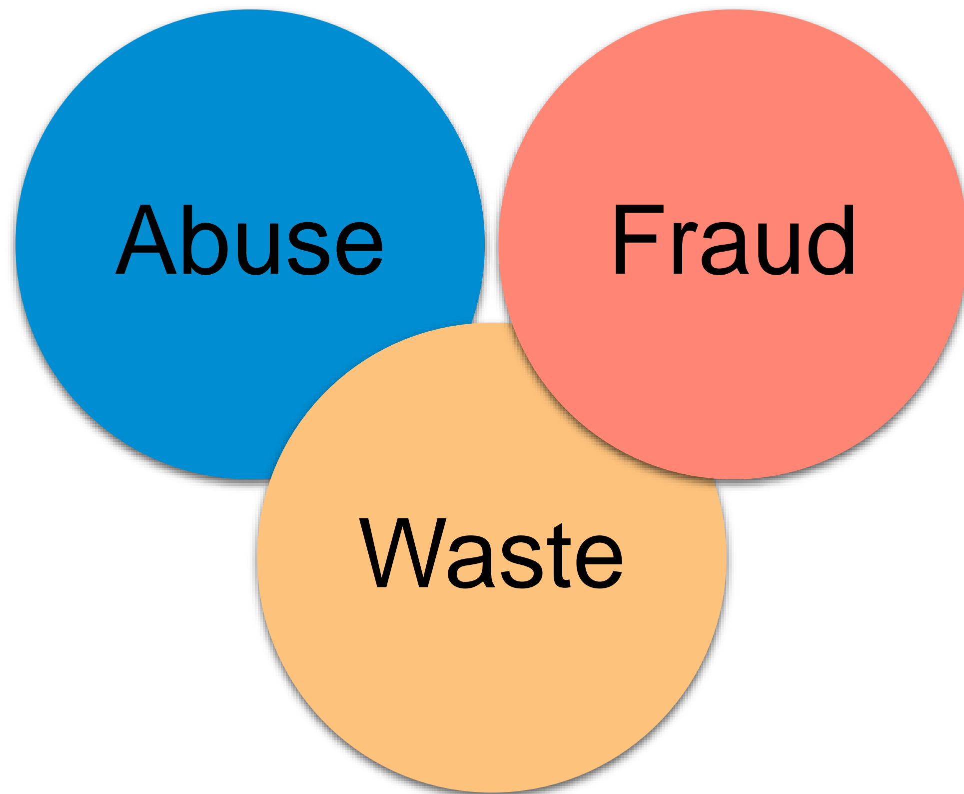
Defining FWA: Differences Between Fraud, Waste, & Abuse



"There are differences among fraud, waste, & abuse. One of the primary differences is intent & knowledge.

Fraud requires intent to obtain payment & the knowledge the actions are wrong.

Waste & abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent & knowledge."

Source: *Combating Medicare Parts C & D Fraud, Waste, & Abuse Web-Based Training Course,* January 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

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FWA Mission

We're a managed care organization that knows that health is about so much more than just doctor's appointments & prescriptions. At Highmark Wholecare, we believe that to truly care for a person's health, we need a different kind of healthcare.

Highmark Wholecare Mission:

To improve the health & wellness of the individuals & the communities we serve by providing access to integrated, superior health care.

Highmark Wholecare's Due Diligence:

Highmark Wholecare's FWA Unit maintains policies & procedures to identify & investigate FWA within the contractual requirements of the PA HealthChoices MCO Agreement (Section V.O.4) & the provisions of the Federal Regulations 42 CFR 438.608 Program Integrity Requirements. Highmark Wholecare's SIU conducts ongoing monitoring of provider network to identify disciplinary action/ sanctions & licensure issues.

Fraud, Waste, & Abuse Mission:

Protect our customers & lower the cost of healthcare by investigating instances of Fraud, Waste, & Abuse & recover overpayments.

Fraud, Waste, & Abuse Strategy:

Utilize data analysis techniques to identify aberrant claims, perform claim coding reviews & conduct a variety of audits using investigative methods to assess the appropriateness of provider payments & pursue overpayment recoveries.

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FWA Team & Functional Areas

A multi-faceted team that is responsible for detecting & investigating fraud, waste, or abuse.

Special Investigations

- The Special Investigations Unit (SIU) is responsible to prevent, detect, & investigate FWA.
- The SIU is comprised of AHFIs, CFEs, Analysts, Consultants, & Investigators.
- The SIU is charged with:
  - Auditing & investigating providers
  - Communicating audit results & coordinating recoveries
  - Collaborating with law enforcement & government agencies

Opportunities & Coding

- The Intake, Triage, & Opportunities (ITO) is responsible for receiving, assessing, & progressing FWA referrals.
- The ITO is comprised of Medical Coders, Analysts, & Investigators.
- The ITO is charged with:
  - Triaging FWA calls & emails
  - Data-mining potential FWA leads
  - Reviewing medical records

FWA Solutions

- The FWA Solutions Unit is responsible for auditing & monitoring of improper payments.
- FWA Solutions is comprised of delegated payment integrity vendors, Financial Analysts, & Collections Specialists.
- FWA Solutions is charged with:
  - Managing vendors
  - Conducting pre-payment reviews
  - Conducting post-payment reviews
  - Collecting provider balances

Compliance & Reporting

- The FWA Team is responsible for ensuring compliance standards & accurate financial reporting.
- The FWA Team is comprised of a medical ethicist, CHCs, AHFIs, CFEs, Medical Coders, Financial Analysts, Consultants, & Investigators.
- The FWA Team is charged with:
  - Maintaining program requirements for FWA
  - Reporting financial data
  - Implementing an effective FWA program

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FWA Functions

What we DO & why

- ✓ Prevent, detect & investigate alleged FWA referrals
- ✓ Identify & recoup inappropriate payments
- ✓ Responsibility to educate providers on what is required.
- ✓ Work with Federal, State & Local law enforcement agencies
- ✓ Believe in maintaining the integrity of services provided to Highmark Wholecare members
- ✓ To ensure services are sustainable in the future

What we DON'T do

- Criminal investigations (Local, State, Federal law enforcement)
- Complaints or grievances
- Approve documentation templates
- Investigate provider related HIPAA concerns
- Licensing
- Investigate quality of care concerns
- Review medical necessity

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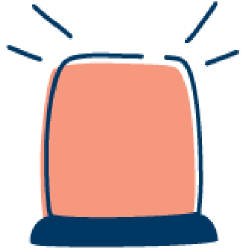
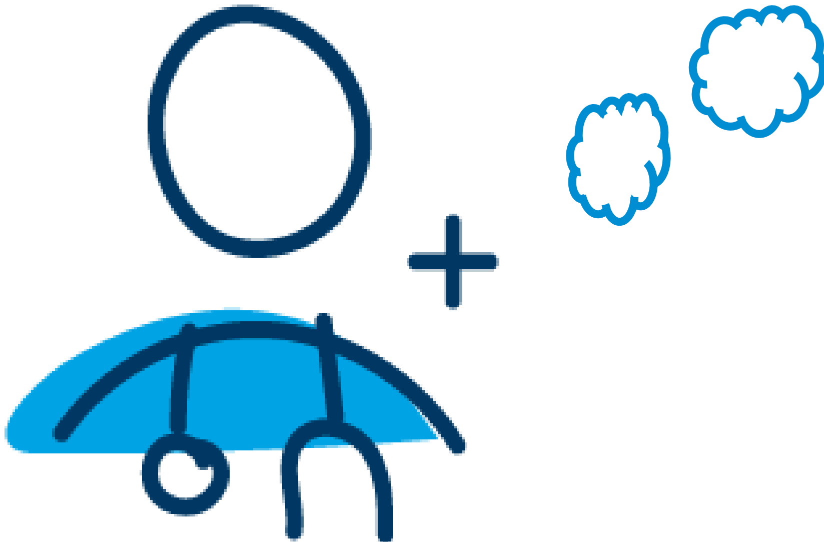
FWA Functions



Red Flags are patterns, practices, or aberrant activities that indicate the possibility of fraud. Through identifying & reporting these activities, YOU can help combat fraud, waste, & abuse.



Examples:

- Billing for services that haven't been rendered
- Unusual/inconsistent billing practices
- Usually high volume or percentage of the same services
- High-dollar member reimbursement claims
- Dates of service not recorded in medical records or that do not match bill dates
- Billing for an amount that doesn't correspond to the services rendered
- Altering receipts or claims
- Pressure to pay claims quickly
- Submitting multiple billings for the same service

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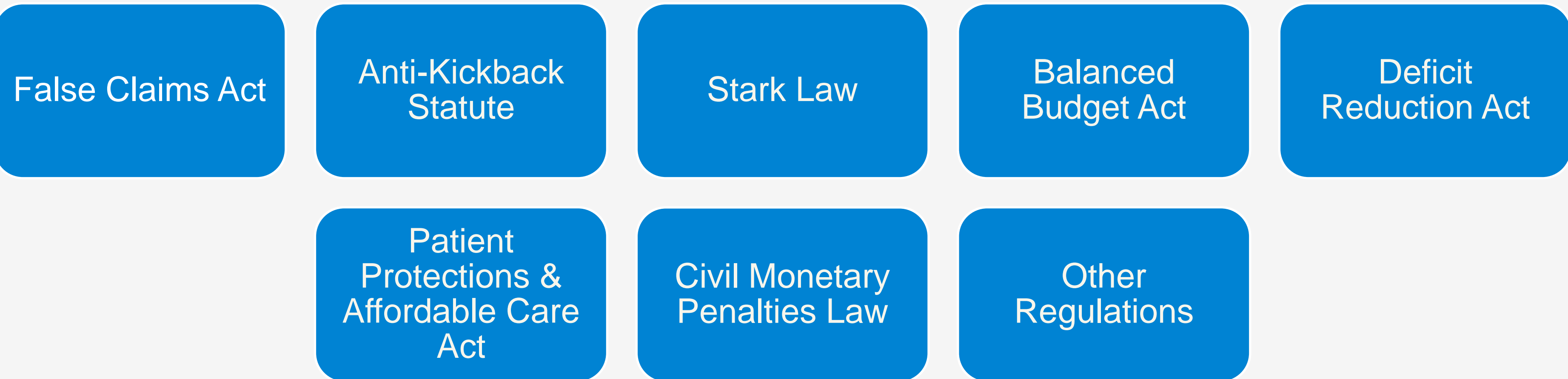
Laws & Regulations



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Laws & Regulations: False Claims Act (“FCA”)

- The civil provisions of the False Claims Act (FCA) make a person liable to pay damages to the government if he or she knowingly:
  - Conspires to violate the False Claims Act
  - Carries out other acts to obtain property from the government by misrepresentation
  - Conceals or improperly avoids or decreases an obligation to pay the government
  - Makes or uses a false record or statement supporting a false claim
  - Presents a false claim for payment or approval

- The FCA penalties & sanctions can include:
  - Fines between $5,000-$10,000 per claim
  - Monetary penalties up to three times the amount of damages
  - Federal & State exclusions

- The FCA includes a *qui tam* provision, where individuals can bring claims on behalf of the Government in exchange for a percentage of any recovery.

For more information, refer to 31 United States Code (USC) Sections 3729–3733

EXAMPLE

June 8, 2021, a Texas Chiropractor & her medical group agreed to pay $2.6 million to resolve allegations that she improperly billed Medicare & TRICARE programs for the implementation of neurostimulator electrodes without performing such surgeries. In addition, she & affiliated medical entities agreed to a 10-year period of exclusion from participation in any federal health care programs.

Wrongful billing results in $2.6M settlement & 10-year exclusion from federal health care programs | USAO-SDTX | Department of Justice

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Laws & Regulations: Anti-Kickback Statute

- The Anti-Kickback Statute prohibits knowingly & willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicaid & Medicare programs).
  - Prohibits asking for or receiving anything of value in exchange for referrals of Federal health care program business.
  - No bribes, kickbacks or other inappropriate payments should be offered or given to any person or entity for any reason including, but not limited to, the acquisition or retention of business.
  - Safe harbors may be applicable.
- Violations of the Anti-Kickback Statute are punishable by:
  - Fines up to $25,000
  - Imprisonment up to 5 years

See 42 United States Code § 1320a-7b for further information

EXAMPLE

October 18, 2021, a Seattle CEO of a medical testing laboratory has agreed to pay $1.1 million to resolve allegations that he received kick-backs from healthcare entities in exchange for referrals of Medicare & TRICARE program business.

DOJ & CEO of defunct medical testing laboratory settle False Claims Act & Anti-Kickback Statute civil case | USAO-WDWA | Department of Justice

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Laws & Regulations: Physician Self-Referral Statute (Stark Law)

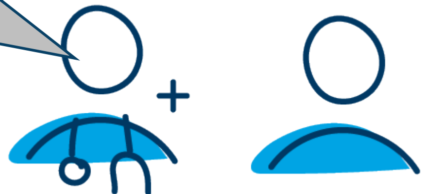
- The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:
  - An ownership/investment interest or;
  - A compensation arrangement.
- Claims tainted by an arrangement that does not comply with the Stark Statute are **not payable.**
- *Exceptions may apply.*

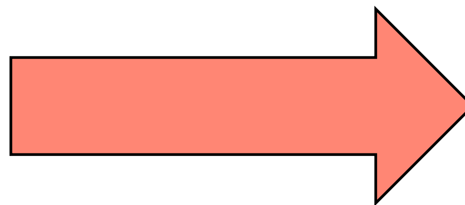
- A penalty of around $24,250 can be imposed for each service provided. There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.
- *For more information, refer* to 42 USC Section 1395nn.

EXAMPLE

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians & physician groups outside the fair market value standards or that were improperly documented as exceptions.

Patient visits Dr. A for care & needs a referral for physical therapy.





Dr. A provides a physical therapy referral to ABC Therapy which is owned by his brother, Dr. B.

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Laws & Regulations

Balanced Budget Act ("BBA")

- The BBA expanded the Office of Inspector General's sanction authorities & established a toll-free fraud & abuse hotline for individuals who suspect that fraud or abuse have occurred in Federal healthcare programs.
- Further amendments to BBA were made in 2002 & require health plans to implement the following measures:
  - Document policies & procedures
  - Articulate a commitment to comply with State & Federal regulations
  - Designate a Compliance Officer & Compliance Committee
  - Develop solid detection & reporting processes
  - Provide education to employees, providers, & members

See Public Law 105-33 *for further information*

Deficit Reduction Act of 2005

- The Deficit Reduction Act of 2005 ("DRA") established the Medicaid Integrity Program, the first comprehensive Federal strategy to reduce fraud, waste, & abuse in the Medicaid program.
- Other examples of anti-fraud provisions enacted by the DRA include strengthening the ability of State Medicaid Agencies to pursue third-party liability, establishing a national expansion of the Medicare-Medicaid data match program, & including incentives for states to enact their own False Claims Act statutes.

See Public Law 109-171 *for further information*

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Laws & Regulations: Patient Protection & Affordable Care Act

- In addition to providing funding to combat healthcare fraud, the Patient Protection & Affordable Care Act ("ACA") enacted a number of provisions targeted toward the prevention of fraud, waste, & abuse. Some of the notable components of the ACA include the following:
    - Established robust screening requirements for providers & suppliers;
    - Expanded the role of Recovery Audit Contractors to Medicaid & Medicare Parts C & D;
    - Required providers to develop a Compliance Plan; &
    - Revisions to the False Claims Act & Stark Law.
- The ACA also adopted new penalties to deter fraud, waste, & abuse, including, but not limited to:
    - Harsher civil & monetary penalties on providers who commit fraud;
    - Increasing the Federal sentencing guidelines for health care fraud offenses involving more than $1,000,000 in losses; &
    - New fines & penalties for providers who fail to return overpayments from Medicare in Medicaid within **60 days.**

See Public Law 111-148 *for further information.*

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Laws & Regulations: Civil Monetary Penalties Law

- The Office of Inspector General (“OIG”) may impose civil penalties for several reasons, including:
  - Arranging for services or items from an excluded individual or entity;
  - Providing services or items while excluded;
  - Failing to grant OIG timely access to records;
  - Knowing of & failing to report & return an overpayment;
  - Making false claims;
  - Paying to influence referrals
- The penalties can be around $15,000 to $70,000 depending on the specific violation.
- Violators are also subject to three times the amount claimed for each service or item.

For more information, refer to 42 USC 1320a-7a & the Act, Section 1128A(a).

EXAMPLE

A California pharmacy & its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated claims to Medicare Part D for brand name prescription drugs the pharmacy could not have dispensed based on inventory records.

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Other Laws & Regulations

Fraud Enforcement & Recovery Act of 2009

- The Fraud Enforcement & Recovery Act of 2009 ("FERA") made a number of changes to False Claims Act, including, but not limited to, broadening the range of conduct that can be subject to false claims prosecution, as well as updates to FCA filing procedures.
- *See Public Law 111-21 for further information.*

21st Century Cures Act

- The 21st Century Cures Act enacted a number of changes to strengthen fraud & abuse measures in the Medicaid program.
  - Requiring states to screen & providers to a centralized database; & Establishing a timeline for states to adopt electronic verification systems.
- *See Public Law 114-255 for further information.*

Criminal Health Care Fraud: Penalties

- Persons who knowingly make a false claim may be subject to:
  - Criminal fines up to $250,000
  - Imprisonment for up to 20 years
- If the violations resulted in death, the individual may be imprisoned for any term of years up to life.
- *For more information, refer to 18 United States Code §1347.*

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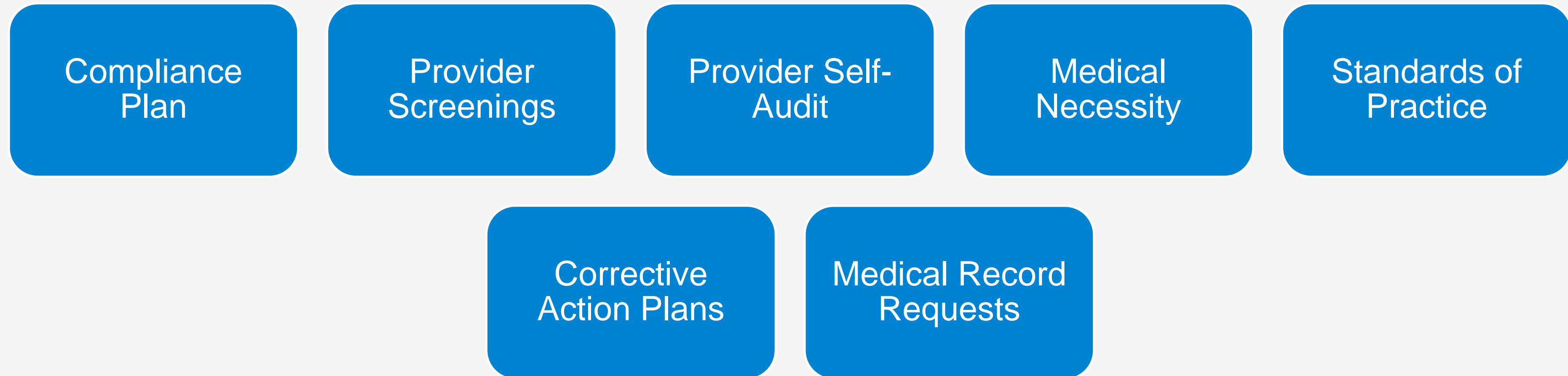
Provider Responsibilities



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Provider Compliance Plan

Providers are required to establish a compliance program that prevents & detects FWA as a condition of enrollment in the Medicare & Medicaid programs.

- All providers are required to have a compliance plan, no matter the size of your practice.
- The Office of the Inspector General providers the following eight guidelines for providers in creating their compliance programs:

1. Conduct internal monitoring & auditing
2. Implement compliance & practice standards
3. Designate a Compliance Officer
4. Conduct appropriate training & education
5. Respond to detected offenses & develop corrective actions
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines
8. Compliance programs MUST be effective

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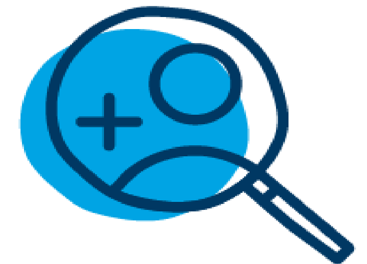
Provider Screenings: PA Medicaid Requirements

- PA Medicaid Bulletin #99-11-05 requires all providers to screen employees, contractors, & subcontractors, individuals, & entities, against the exclusion databases as required by forty-two (42) CFR §455.436 to determine if they have been excluded from participation in Medicaid or Medicare. No Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded. 42 CFR § 1001.1901(b). DHS has advised providers to conduct self-audits to determine compliance with this requirement & report any discovered exclusion of an employee or contractor, either an individual or entity, to DHS' Bureau of Program Integrity ("BPI").

- Below are links to the exclusion databases:
  - Federal Department of Health & Human Services, Office of Inspector General – List of Excluded Individuals & Entities:
    - https://exclusions.oig.hhs.gov/
  - Federal General Services Administration, System for Award Management:
    - https://sam.gov/content/home
  - PA Department of Human Services – Medicheck System:
    - https://www.humanservices.state.pa.us/Medchk/MedchkSearch/Index



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Provider Screenings

Per the provider contracts, Highmark Wholecare requires providers to conduct employee sanction checks, complete all credentialing requirements, review exclusions, & check criminal background checks of all practitioners & clinicians. Additionally, Highmark Wholecare requires the following verifications:

A current, unrestricted license → Fully completed & attested CAQH application → Active individual MPI number → NPI number → Resume/CV with work history to include month & year → Copy of current, unencumbered DEA certificate → Current hospital admitting privileges for PCP → Malpractice history as subject to decision by Highmark Wholecare → Practitioners must maintain professional liability coverage → Active participation in the Medicare & Medicaid programs → ECFMG certificate, if applicable

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Provider Self-Audits: Required by DHS & OIG

- Providers can submit overpayments to Highmark Wholecare by using the Provider Self-Audit Overpayment form found on our website
- Both DHS & OIG require providers to conduct self-audits to identify documentation errors & potential overpayments
- Federal & state laws & regulations require overpayments to be returned within ***60 days*** of identification

Resources for Self-Audits:
DHS Guidance
OIG Guidance

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Medical Necessity - Pennsylvania Regulations

55 Pa. Code § 1101.21

- *Medically necessary*—A service, item, procedure or level of care that is:
  1. Compensable under the MA Program.
  2. Necessary to the proper treatment or management of an illness, injury or disability.
  3. Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

55 Pa. Code § 1101.21a

- *A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:*
  1. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
  2. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, Injury or disability.
  3. Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient & those functional capacities that are appropriate of recipients of the same age.

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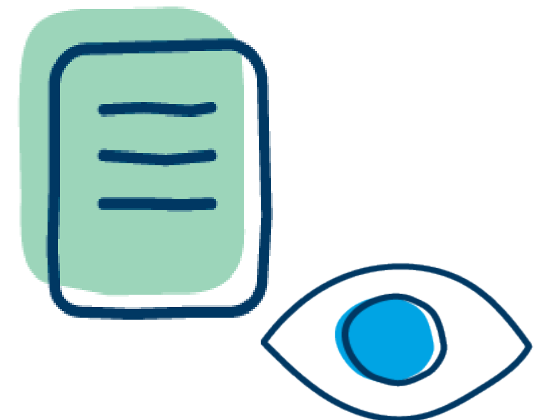
Medical Necessity – CMS Guidance

- The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable & necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member.

- Medically necessary refers to services or supplies that:
  - are proper & needed for the diagnosis or treatment of the member's medical condition;
  - are used for the diagnosis, direct care, & treatment of the member's medical condition;
  - meet the standards of good medical practice in the local community; &
  - are not mainly for the convenience of the member or the doctor.

- These requirements are also included in the 2022 Medicare Assured Provider Manual



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Standards of Practice - Pennsylvania Regulations

Record Requirements

- Providers shall maintain medical records that fully disclose the nature & extent of the services rendered to MA recipients & that meet the criteria established in this section & additional requirements established in the provider regulations:
  - The record shall be legible throughout.
  - The record shall identify the patient on each page.
  - Entries shall be signed & dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed & dated.
  - The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.

Additional Standards of Practice

- In addition to licensing standards, the Pennsylvania Code establishes basic standards of practice to which every practitioner providing medical care to MA recipients is required to adhere.
  - Maintenance of a proper record for each patient.
  - A patient's diagnosis, provisional or final, shall be reasonably based on the history & physical examination.
  - Treatment, including prescribed drugs, shall be appropriate to the diagnosis.
  - Diagnostic procedures & laboratory tests ordered shall be appropriate to confirm or establish the diagnosis.
  - Consultations ordered shall be relevant to findings in the history, physical examination or laboratory studies.
  - The principles of medical ethics shall be adhered to a rendered, ordered or prescribed service.

Payment will not be made when the review of a practitioner's medical records reveals instances where these standards have not been met.

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Corrective Action Plans (“CAPs”)

The FWA Unit may recommend a CAPs for providers.

- An investigation of a provider for aberrant behavior that results in overpayments may require a CAP. There may be other circumstances in which a CAP is needed, such as actions that may cause potential harm to patients, quality of care issues, & inappropriate behaviors.
- The Fraud Analyst will consult with Highmark Wholecare FWA Management, the Fraud Consultant &/or other Highmark Wholecare FWA Associates to determine if a CAP is needed. Other internal departments may be requested to provide feedback on corrective actions for a provider or member in the event that additional opinions are needed to bring resolution to a case.

CAP Elements

1. Date
2. Findings
3. Timeframe of CAP
4. Type of Actions
5. Duration of CAP

If at any time the provider fails to fulfill the requirements of their CAP, the Analyst will discuss next steps with Highmark Wholecare FWA Management. Noncompliance to the terms of the CAP can result in further provider action, which can include, but is not limited to, the following:

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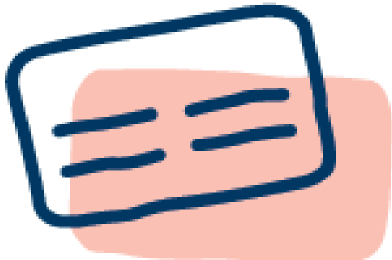
Medical Record Requests

Highmark Wholecare's SIU will conduct retrospective reviews of claims & medical records to ensure claims accuracy & documentation standards.

- Provider must provide requested records at no cost to Highmark Wholecare.
  - This includes notifying any third party vendor who may maintain medical records of this stipulation.



- All requested documentation must be submitted at the time of the medical record request within 30 days from the letter date

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Documentation Requirements

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Minimum Documentation – Highmark Wholecare Provider Manual

Highmark Wholecare requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions & Code Sets, Medicaid regulations, & Medicare manuals as well as other applicable professional associations & advisory agencies Providers should follow the below guidelines for basic medical records:

- Providers are responsible for following all requirements under Federal & State regulations, publications, & bulletins that are pertinent to the treatment & services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals, & all regulations.
- Providers must have member records that include all Medicaid &/or Medicare requirements, are individual & kept secure.
- Providers are responsible for obtaining the appropriate order, referral, or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes & billing forms must be completed after the session.
- All documentation & medical record requirements must be legible.
- All amendments or changes to the documentation must be signed & dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.

- Additionally, the medical records must have the following:
  - Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals & periodic updates
  - High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social & emotional risks, etc.,)
  - Continuity of care is documented
  - Immunizations & dates
  - Must be easy to read & legible
  - Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
  - Allergies & Adverse Reactions
  - Significant illnesses & medical conditions
  - Laboratory & other studies ordered

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Minimum Documentation: CMS – Documentation Matters Toolkit

- Providers are responsible for documenting each patient encounter completely, accurately, & on time.
- Because providers rely on documentation to communicate important patient information, incomplete & inaccurate documentation can result in unintended & even dangerous patient outcomes.
- Accurate documentation supports compliance with federal & state laws & reduces fraud, waste, & abuse.

CMS Resources

Documentation Matters Fact Sheet for Medical Professionals:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-medicalprof-factsheet.pdf

Documentation Matters Fact Sheet for Behavioral Health Practitioners:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf

Documentation Matters Fact Sheet for Medical Office Staff:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf

Medical Records Resource Guide:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-recorddoc-resourceguide.pdf

Electronic Health Records Fact Sheet:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

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Consent to Treatment

Pennsylvania Regulations

- The PA Code establishes prohibitions on provider conduct, including rendering services without patient consent.
- 55 Pa. Code § 1101.75 - Provider Prohibited Acts: (a) An enrolled provider may not, either directly or indirectly, do any of the following acts:
  - (10) Except in emergency situations, render or provide a service or item without a practitioner's written order & the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient

Highmark Wholecare Provider Manual

- Valid for dates of service (update yearly)
- Identifies the patient
- Signed & dated by the patient
- Signed, dated & credentialed by the clinician
- List types of services &/or treatments
- Includes the benefits & potential risks
- Includes alternative services &/or treatments
- Must be easy to read & legible

Consent to Treatment forms should be updated yearly, signed & dated by member & provider. If the member is under the age of 18, then a parent or guardian would need to sign a Consent to Treat form on behalf of the member.

References:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf
https://www.ama-assn.org/delivering-care/ethics/informed-consent
https://www.thedoctors.com/articles/informed-consent-substance-and-signature/
https://forum.ashrm.org/2019/02/27/clarifying-informed-consent/

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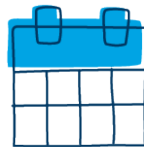
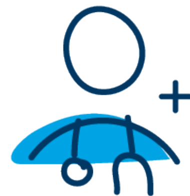
Release of Information for Payment

Provider Manual Requirements

- Identifies the patient
- Signed & dated by the patient
- Signed, dated & credentialed by the clinician
- List types of services &/or treatments
- Must be easy to read & legible

These requirements are included in the [2021 Medicaid Provider Manual] & the [2022 Medicare Assured Provider Manual]

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HIPAA & Privacy Practices

- HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, & promoted standardization & efficiency in the health care industry.
- HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.
- The Privacy Rule of the Health Insurance Portability & Accountability Act ("HIPAA") requires covered entities to distribute a notice of their privacy practices to patients with respect to their protected health information.
  - Information regarding uses & disclosures of PHI
  - Patient's individual rights
  - Provider's duties
  - Complaints
  - Contact Information
- Privacy Practices are outlined in the Highmark Wholecare Provider Manual to include the following:
  - Valid for dates of service
  - Identifies the patient
  - Signed & dated by the patient
  - Signed, dated & credentialed by the author/clinician
  - Must be easy to read & legible
- *For more information, visit the www.hhs.gov/hipaa/index.html or 45 CFR § 164.520*

Damages & Penalties

Violations may result in civil monetary penalties. In some cases, criminal penalties may apply.

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Treatment Plan

Pennsylvania Regulations

- The PA Code establishes general standards for medical records, including the entry of a treatment plan.
- 55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services & suppliers of medical goods & equipment shall keep patient records that meet all of the following standards:
  - (v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities & dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect

These requirements are included in the 2021 Medicaid Provider Manual & the 2022 Medicare Assured Provider Manual.

Highmark Wholecare Provider Manual

- Identifies the diagnosis
- Identifies interventions & goals of treatment
- Document necessity for treatment
- Reviews are completed timely as applicable
- Must be easy to read & legible
- Valid for dates of service
- Identifies the patient
- Signed & dated by clinician (witness or author's identification)
- Documents that member or guardian reviewed or participated with the development of the treatment plan

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Medication List

Pennsylvania Regulations

- The PA Code establishes general The Pennsylvania Code establishes standards for medical records, including the entry of a patient's medication
- 55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services & suppliers of medical goods & equipment shall keep patient records that meet all of the following standards:
  - (v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities & dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect

These requirements are included in the 2021 Medicaid Provider Manual & the 2022 Medicare Assured Provider Manual.

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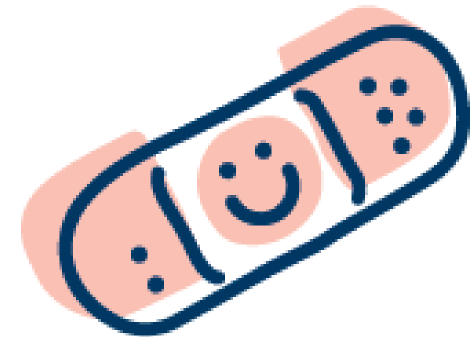
- Medication prescribed
- Signed & dated by clinical
- Lists dosages, dates & refills
- References the side effects & symptoms
- Must be easy to read & legible



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Progress Notes

Pennsylvania Regulations

- The Pennsylvania Code establishes standards for medical records, including the entry of progress notes
- 55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services & suppliers of medical goods & equipment shall keep patient records that meet all of the following standards:
  - (vi) the record shall indicate the progress at each visit, change in diagnosis, change in treatment & response to treatment

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- Dates of service
- Identifies the patient
- Signed, dated & credentialed by author/clinician
- Start & stop times for time-based services
- Units of service
- Place of service

These requirements are included in the 2021 Medicaid Provider Manual & the 2022 Medicare Assured Provider Manual.

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Types of Investigations

- Overview
- Routine Investigations
- Progressive Audits
- Other SIU Activities
- FWA Solutions

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Highmark Wholecare FWA Activities

Highmark Wholecare' s FWA Team works to ensure that claims are paid correctly by both monitoring & auditing methods & in accordance to recipient benefits & provider contracts.

FWA

- Routine Audits
- Investigations
- Data Mining
- Provider Reviews
- Vendor Partnerships
- Member Verification
- Claims Edits

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Routine Investigations

Investigation of a reported allegation related to organizational activities for potential fraud, waste, & abuse.

- Conduct Data Analysis
- Review Contract/ Provider Credentialing
- Review Internal Policy for Coding
- Review State/Federal Guidelines
- Member & Provider Interviews

Routine Investigations

- Coordinate with Other Departments
- Overpayment Notification
- Recoupment of Overpaid Dollars
- Submit State & CMS Referrals
- Local, State, & Federal Collaboration

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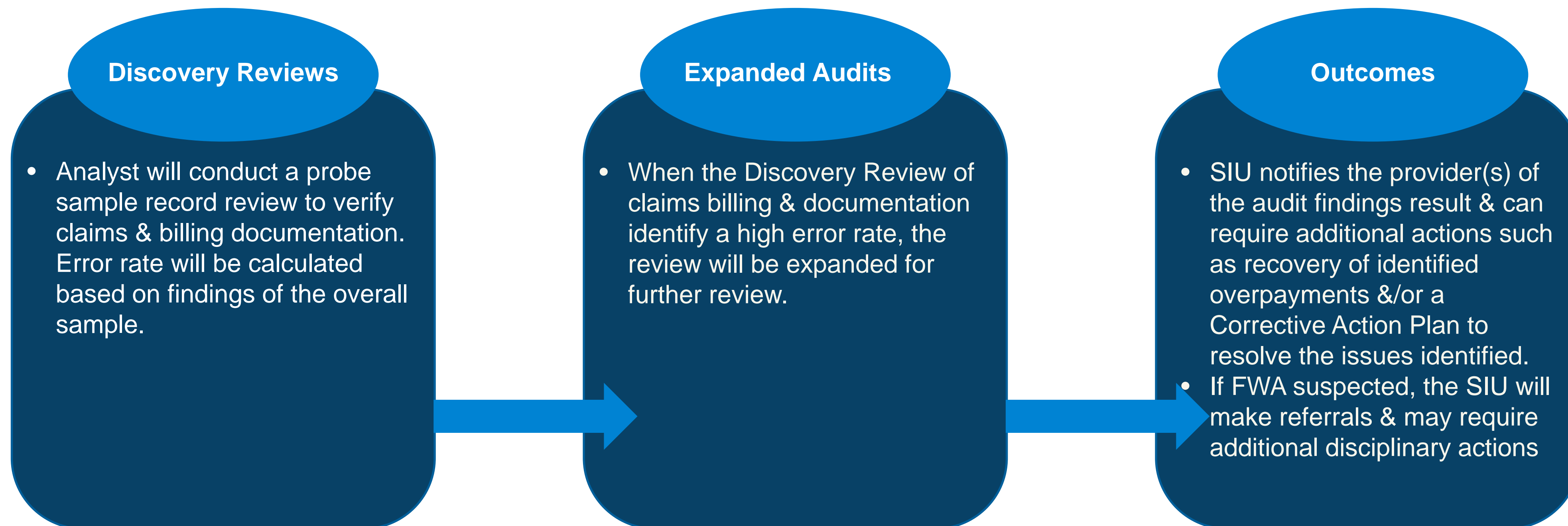
Progressive Audits ("Routine Audits")

- Highmark Wholecare's SIU relies on the progressive audit model for conducting specific audits which focus on provider specialties identified in an annual audit work plan.
- The providers selected will encounter stages of the audit based on claims billing & documentation error rates. The progressive audit stages are the discovery reviews, expanded audits & outcomes



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Other SIU Activities

Recurring Overpayment Projects

- SIU conducts data analysis to monitor claims billing on a reoccurring basis (monthly, quarterly, or yearly) in order to identify aberrant claim payments made. Overpayments can occur from the inability to systematically correct an issue, claim adjudication error, & provider submission errors.
- Examples include:
  - Surgical Unbundling
  - Member & Provider eligibility

Requests for Information (“RFIs”)

- Request for Information (RFI) are incoming requests sent by regulatory or law enforcement agencies to Managed Care Organizations (MCOs) like Highmark Wholecare. These requests require MCOs to pull specific information including, but not limited to, claims data, contracts etc.
- Sources include:
  - DHS & BPI
  - CMS
  - I-MEDIC
  - OIG HHS
  - Attorney General & MFCU
  - FBI

Provider Education & Training

- Highmark Wholecare’s FWA Team assures that its beneficiary & provider populations are also educated on healthcare FWA issues. Methods of educating include:
  - Fraud & Abuse webpage
  - Quarterly newsletters
  - Audit finding notifications, including CAPs
  - Explanation of benefits statements
  - Provider & member forums
  - Provider & member manuals

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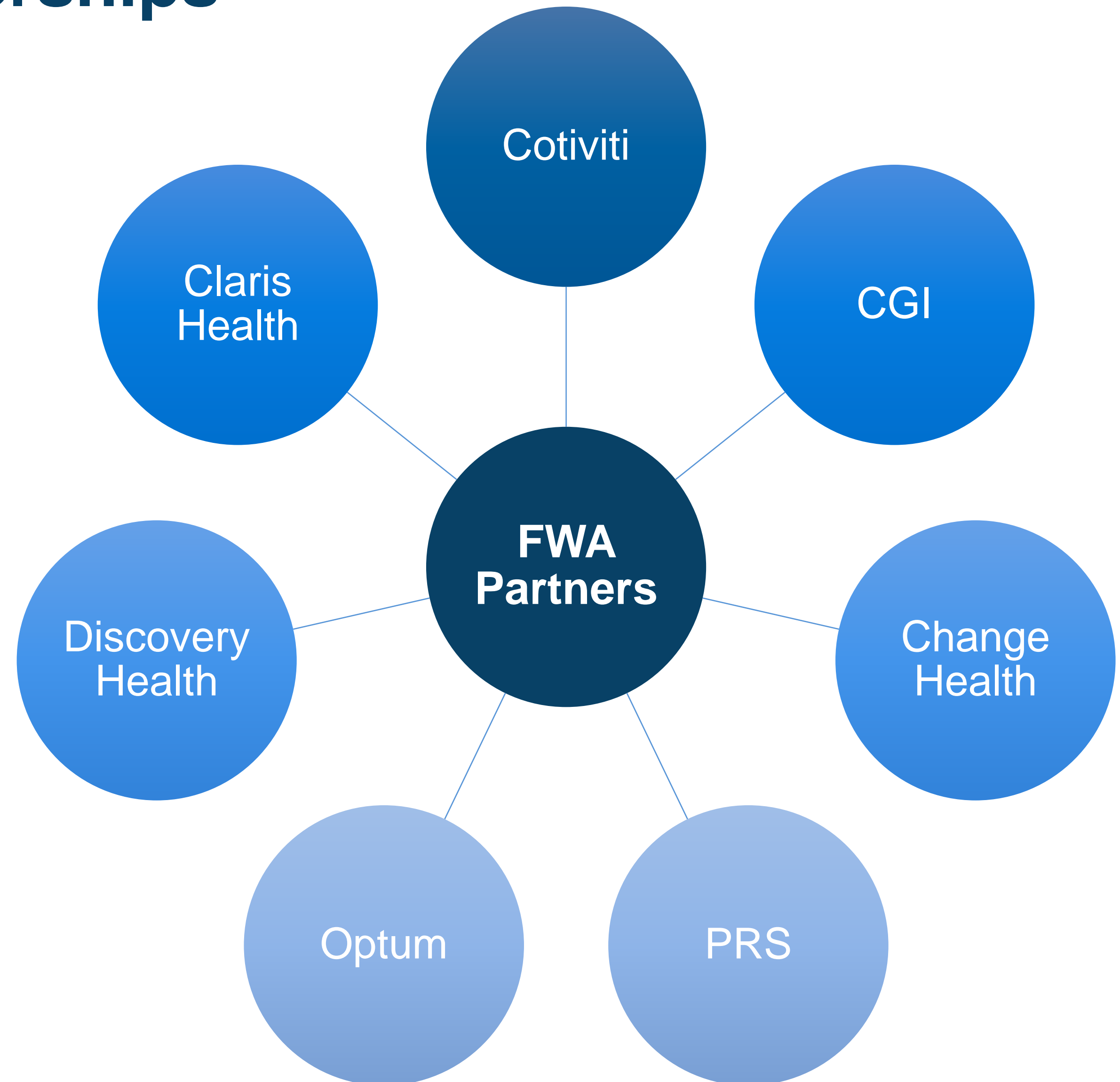
FWA Solutions – Vendor Partnerships

- Pre-payment Edits & Reviews
  - FWA contracts with Vendors to monitor claims prior to payment to ensure claims accuracy. FWA has the capability to suspend claims to conduct pre-payment reviews prior to releasing payment to flagged Providers.
- Post-payment Audits
  - FWA contracts with Vendors to audit claims through retrospective reviews.
- Other contracted vendors of Highmark Wholecare specialize in the following oversight activities that may include:
  - Ensuring payment accuracy
  - Inpatient/Outpatient Chart Reviews
  - Clinical Validation
  - Complex system edit set-ups
  - Data mining trending healthcare patterns
  - Contract Compliance



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Outcomes for Noncompliance

- Prohibited Acts
- Provider Terminations & Suspensions
- Recovery of Overpayments
- Provider Sanctions & Penalties

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Consequences of Committing FWA

Laws & regulations exist that prohibit FWA. Penalties for violating these laws may include:

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Prohibited Acts – Federal Regulations

Pre-payment Edits & Reviews

- 42 CFR § 482.24: Medical record requirements
- 42 CFR § 482.32: Basic requirements for all claims
- 42 CFR § 402.1: Civil money penalties, assessments, and exclusions

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Prohibited Acts – Pennsylvania Regulations

- The Pennsylvania Code prohibits providers enrolled in the Medical Assistance program from engaging in certain acts. A comprehensive listing of these prohibited acts can be found at 55 Pa. Code § 1101.75.

- 55 Pa. Code § 1101.76: A provider or person who commits a prohibited act may be subject to the following penalties:
    - criminal penalties;
    - enforcement actions by DHS; &
    - restitution & repayment

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Prohibited Acts – Pennsylvania Regulations

Providers may not, either directly or indirectly, engage in any of the following acts:

- Knowingly or intentionally present for allowance or payment a false or fraudulent claim under MA
- Knowingly present for allowance or payment a claim for medically unnecessary services or merchandise under MA
- Knowingly submit false information, for the purpose of obtaining greater compensation than that to which the provider is legally entitled under MA.
- Knowingly submit false information to obtain authorization to furnish services or items under MA.
- Solicit, receive, offer or pay a remuneration, including a kickback, bribe or rebate, directly or indirectly, in cash or in kind, from or to a person in connection with furnishing of services or items or referral of a recipient for services & items.

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Prohibited Acts – Pennsylvania Regulations

Providers may also not engage, either directly or indirectly, in any of the following regarding claim submissions:

- Submit a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.
- Submit a claim for services or items which were not rendered by the provider or were not rendered to a recipient.
- Submit a claim for services or items which includes costs or charges which are not related to the cost of the services or items.
- Submit a claim or refer a recipient to another provider by referral, order or prescription, for services, supplies or equipment which are not documented in the record in the prescribed manner & are of little or no benefit to the recipient, are below the accepted medical treatment standards, or are not medically necessary.
- Submit a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.
- Submit a claim for a service or item at a fee that is greater than the provider's charge to the general public.

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Prohibited Acts – Pennsylvania Regulations

Providers may also not engage, either directly or indirectly, in any of the following:

- Except in emergency situations, dispense, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient.
- Enter into an agreement, combination or conspiracy to obtain or aid another in obtaining payment from the Department for which the provider or other person is not entitled, that is, eligible.
- Make a false statement in the application for enrollment or reenrollment in the program.
- Commit certain prohibited acts relating to providers practicing in the shared health facility.

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FWA Review Outcomes

Investigation & Audit Outcomes

- The SIU will notify providers of the findings
- Overpayments must be refunded within 60 days
- Additional disciplinary actions may be applied to address contractual or regulatory deficiencies

Recovery of Overpayments

- If any of FWA efforts identify overpayments, the following activities will occur:
- Identify overpayments;
- Highmark Wholecare will pursue recoveries of overpayments through claims adjustments with recoveries by claims offsets or provider checks within 60 days;
- Highmark Wholecare will refer suspected FWA to appropriate agencies, such as Medicaid oversight & CMS Medics; &
- Highmark Wholecare may recommend corrective actions that may include pre-payment review, payment suspension & potential termination from Highmark Wholecare's provider network.

Disciplinary Actions

- Fraud referrals to government agencies & law enforcement
- Provider Self-Audit of remaining populations based on OIG & Medicaid requirements
- Pre-pay review
- Payment Suspensions
- Error extrapolation
- Quality of Care reviews
- Continued CAP adherence
- Termination from network

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Resources

Medicaid Resources
- PA Medicaid Guidelines
- Forms & Reference Materials
- Provider Updates
- Provider Manual

Medicare Resources
- Medicare Guidelines
- Forms & Materials
- Provider Updates
- Provider Manual

Highmark Wholecare Fraud & Abuse Website
Pennsylvania Department of Human Services Website
MA Program Payment Policies
Provider Responsibilities
DHS Self-Audit Protocol
CMS Fraud & Abuse Website
CMS Self-Audit Snapshot
OIG Provider Self-Disclosure Protocol

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Thank you!