CareMore HEALTH

CareMore's Compliance 101

GENERAL COMPLIANCE TRAINING FOR PROVIDERS

LAST REVISED: MARCH 2021

Training Roadmap

Introduction

- Background/Training Goals
- CareMore's Code of Conduct
- Non-Compliance Explained

Roles and Responsibilities

- CareMore's Role
- Your Role as a Provider
- Conflicts of Interest
- Privacy Protection
- Documentation, Coding and Billing

Key Laws to Know

- Fraud, Waste and Abuse
- Consequences of Non-Compliance

Reporting Concerns

- How to Report

Background

- The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees Medicare and Medicaid programs, as well as the state and federal health insurance marketplaces.
- CMS contracts with CareMore to provide care for Medicare patients, as well as other programs.
- CMS requires CareMore to provide compliance training to all new providers.
  - Training must occur within 90-days of the effective date of your contract with CareMore, and annually going forward.

Goals of Today's Training

While this training is a CMS requirement, our goal extends much further to:

- Help you understand your unique role as a provider
- Empower you to help prevent, detect and report wrongdoing
- Give you the tools to conduct yourself with the highest standards of integrity

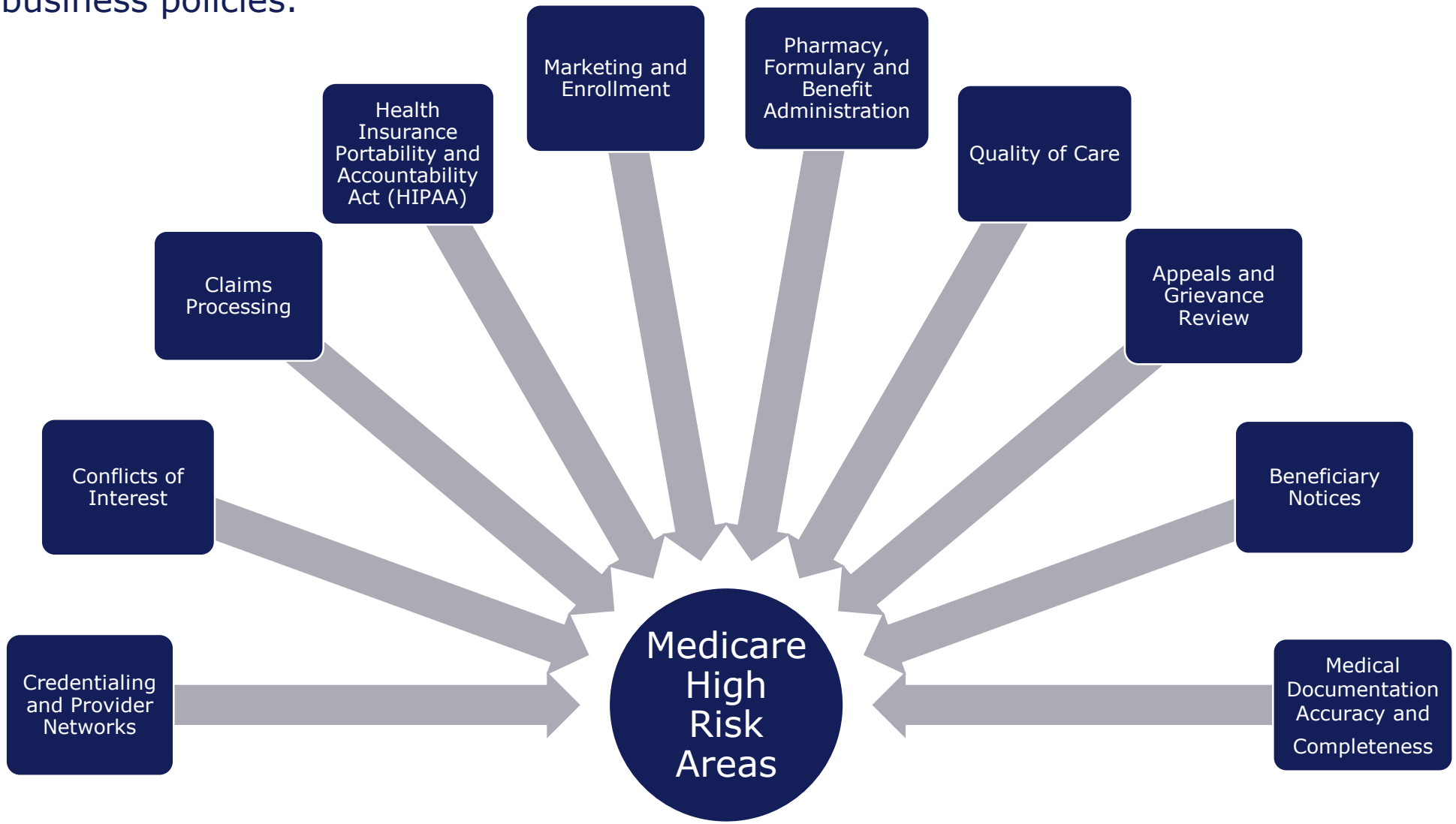
CareMore's Code of Conduct

Our Code supports our values:

- **Leadership:** Redefine what is possible
- **Community:** Committed, connected, invested
- **Integrity:** Do the right thing, with a spirit of excellence
- **Agility:** Deliver today – transform tomorrow
- **Diversity:** Open your hearts and minds

What is Non-Compliance?

Conduct that doesn't conform to the law, federal healthcare program requirements, or CareMore's Code of Conduct and business policies.



Non-Compliance Examples

Non-Compliance includes more serious cases like patient and provider fraud.

Patient Fraud Examples	Provider Fraud Examples
Using someone else's insurance card	Intentionally assigning a more severe diagnoses to inflate reimbursement
Forging or altering bills or receipts	Intentionally billing codes for a more expensive treatment than was provided

Non-Compliance Isn't Always Intentional

Serious (and costly) violations can be created from little mistakes.

Mount Sinai St. Luke's hit with lawsuit after faxing man's HIV status to his employer

The suit claims that the stress of knowing his coworkers could know about his HIV status caused the man to quit his job and lose his health insurance benefits.

By ERIN DIETSCHE

Post a comment / Sep 12, 2017 at 3:51 PM

A patient in his early 30s has filed a $2.5 million lawsuit against New York City-based Mount Sinai St. Luke's Hospital for faxing his HIV status to his workplace, the Actors Equity Association, according to the *New York Daily News*.

Roles and Responsibilities

CareMore's Role in Compliance

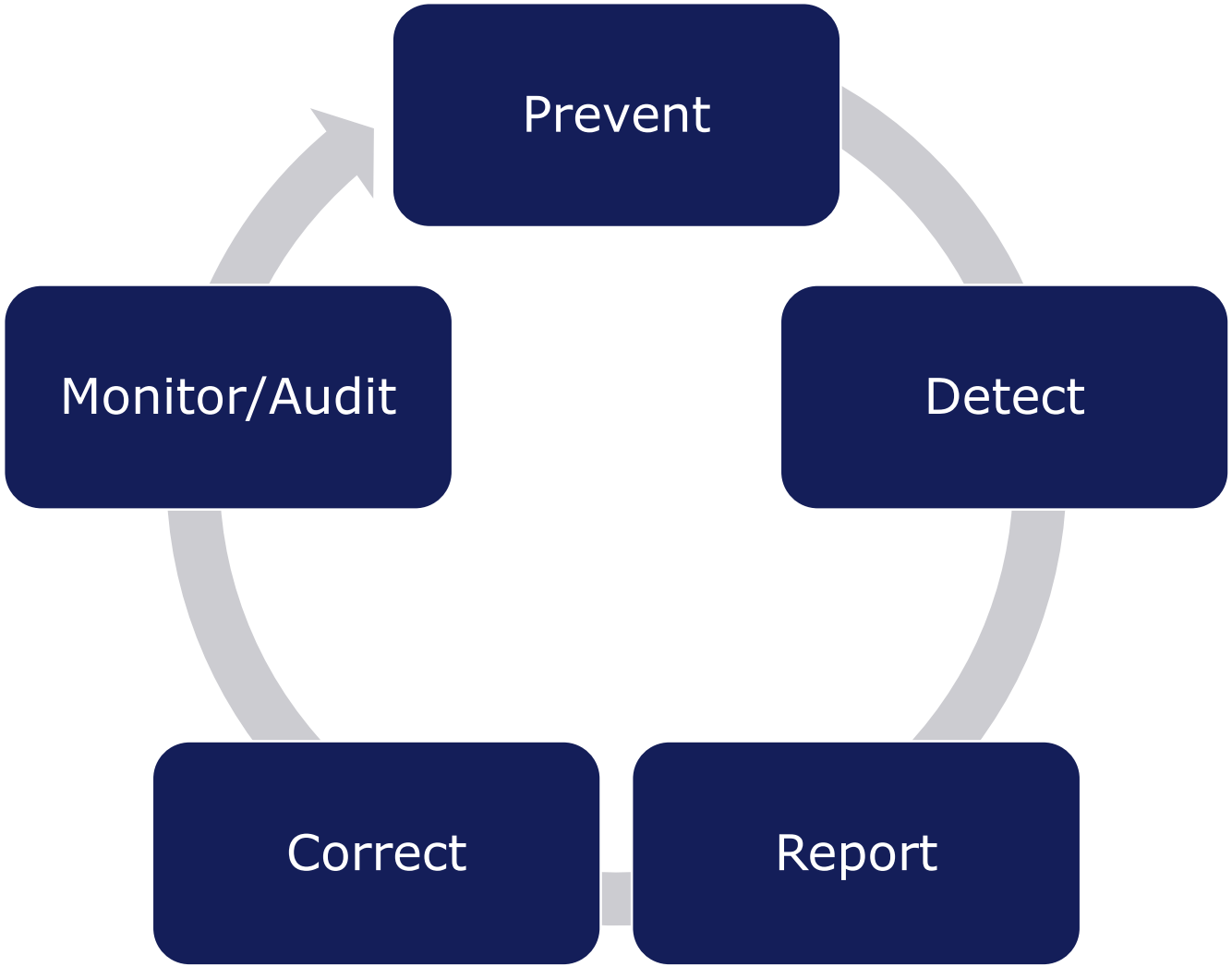
CareMore has implemented a compliance program to help detect and prevent violations, both big and small.

Seven Elements of an Effective Compliance Program:

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 System for Routine Monitoring, Auditing, and Identification of Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

Sources: CMS Medicare Managed Care Manual, Ch. 21 Compliance Program Guidelines; DOJ, Crim. Div., Evaluation of Corporate Compliance Programs, June 2020; OIG, Health Care Compliance Program Tips

CareMore's Compliance Program in Action



Your Role in Compliance

Help Prevent

Understand and adhere to laws, regulations and policies

Complete all required trainings on time

Ensure coding, documentation and billing is accurate and timely

Protect patient confidentiality and privacy

Asks questions if you are unsure of a requirement

Help Detect and Correct

Cooperate with auditing and monitoring activities

Participate, cooperate and be truthful in internal investigations

Report Conflicts of Interest (COI)

A COI is a financial, business or other relationship which puts you at odds with CareMore's interests or conflicts with your assigned duties.

- Examples of a potential COI:
  - Board participation
  - Political activities
  - Family member working for Anthem

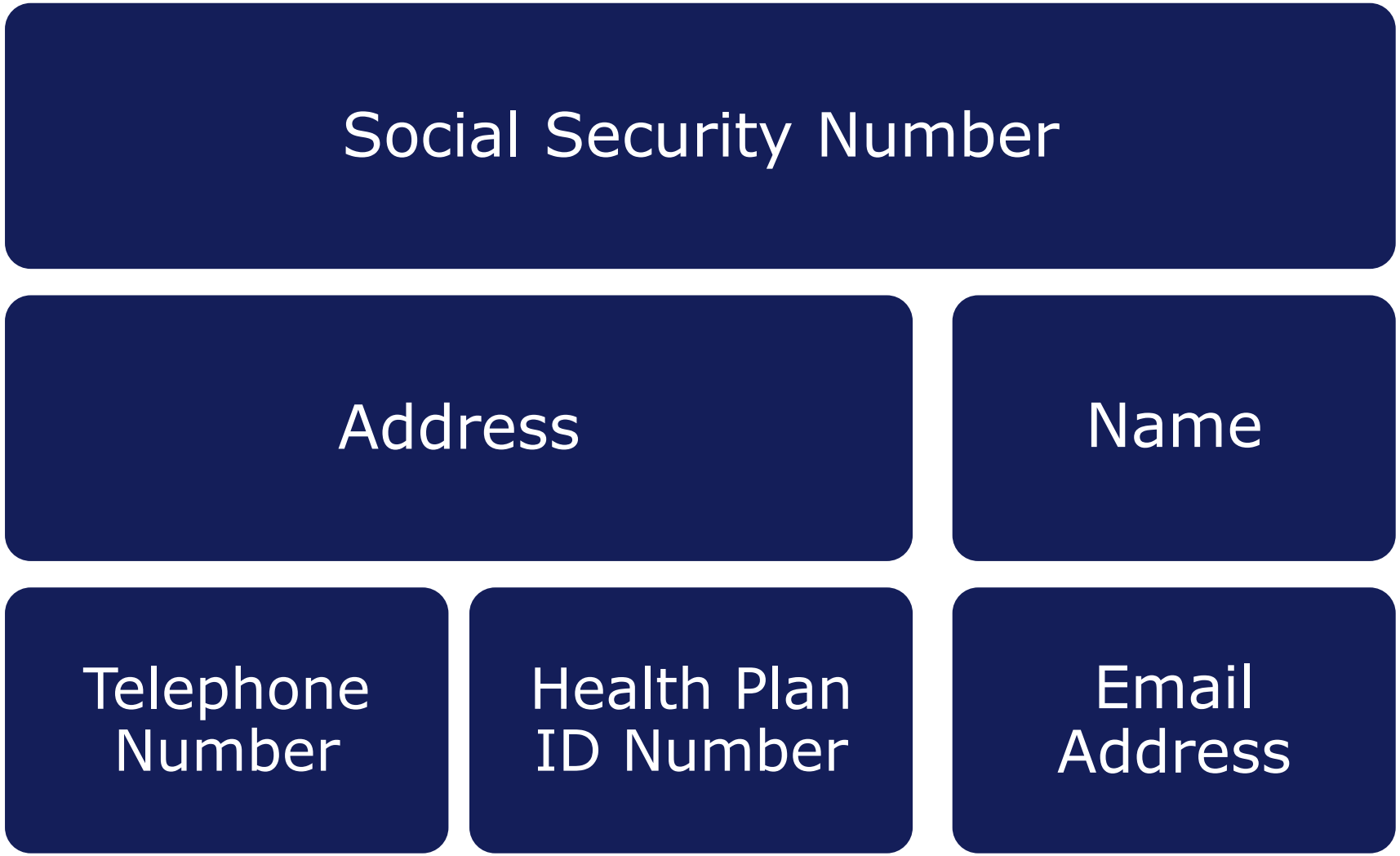
If you are uncertain whether a conflict exists, ask yourself if you would want the arrangement to appear in the news

Privacy Protection

- Can you imagine going to the doctor and having your visit information shared inappropriately?
- That's why we are required by federal and state law to safeguard Protected Health Information (PHI).
- PHI means:
  - Past, present or future physical or mental health or condition
  - The provision of health care to the individual
  - The past, present, or future payment for the provision of health care to the individual
  - Information that could be used to identify an individual that links to their health status

Unless for treatment, payment for treatment, operations, and other specific exceptions, PHI may not be disclosed without prior authorization from the patient

PHI Examples



Patient Privacy Rights

Under the Health Insurance Portability and Accountability Act (HIPAA), patients have privacy rights that include:

PHI Access

Patients can ask to see or get a copy of their medical records and health information

- Access to certain information, such as psychotherapy notes, and information compiled in anticipation of legal proceedings, is prohibited
- Access is only available as long as records are maintained

In most cases, copies must be provided within 30 calendar days, though some states require faster processing

PHI Amendments

Patients can ask to change any wrong information in their records or add information if they believe something is missing or incomplete

Knowledge of Who Has Seen PHI

Patients can ask how their health information is used and shared by providers

Why Privacy Protections Matter

Not Protecting PHI Can Lead to:
--Loss of patient trust
--Risk of identity theft
--Harm to our reputation
--Audits, fines and sanctions

Allergy practice pays $125,000 for doctor's inappropriate disclosure of PHI

Posted in: HIPAA, HIPAA Violations | By: Art Gross | December 4, 2018

The Office for Civil Rights (OCR) has reached a $125,000 settlement with Allergy Associates of Hartford, P.C. for a HIPAA violation dating back to February 2015.

According to the agency, who released a statement on November 26, the violation occurred when an Allergy Associates' patient contacted a local television station to discuss a dispute that occurred with a doctor of the practice. Following the conversation, a reporter contacted the doctor, who responded to the dispute allegations by impermissibly disclosing that patient's protected health information.

What Can We Disclose?

The minimum amount of PHI necessary for patient treatment, payment, and other activities related to care.

PHI Disclosure

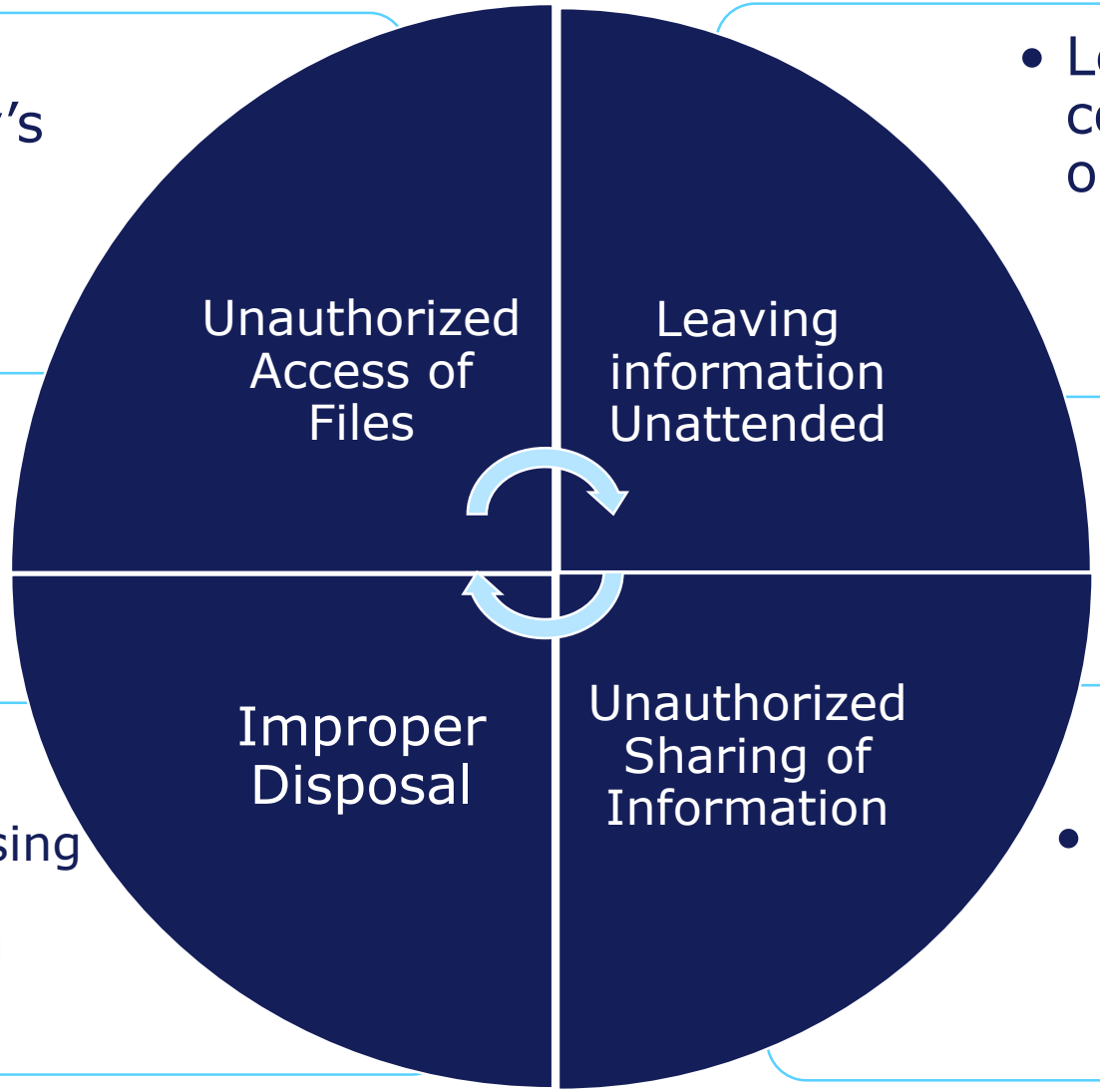
Under certain circumstances, PHI may be used or disclosed without first obtaining patient authorization, but always remember to provide the minimal amount of information needed to do the job.

Area	PHI Permitted Use/Disclosure
Treatment	Treating patients, referring patients, and coordinating care
	Submitting prescriptions
Payment	Pre-certifying procedures, billing premiums, and reimbursement
	Paying claims
Operations	Answering patient calls, providing case management
	Responding to an audit
	Performing quality assurance

Common Privacy Violations

- Looking at your friends or family's medical records

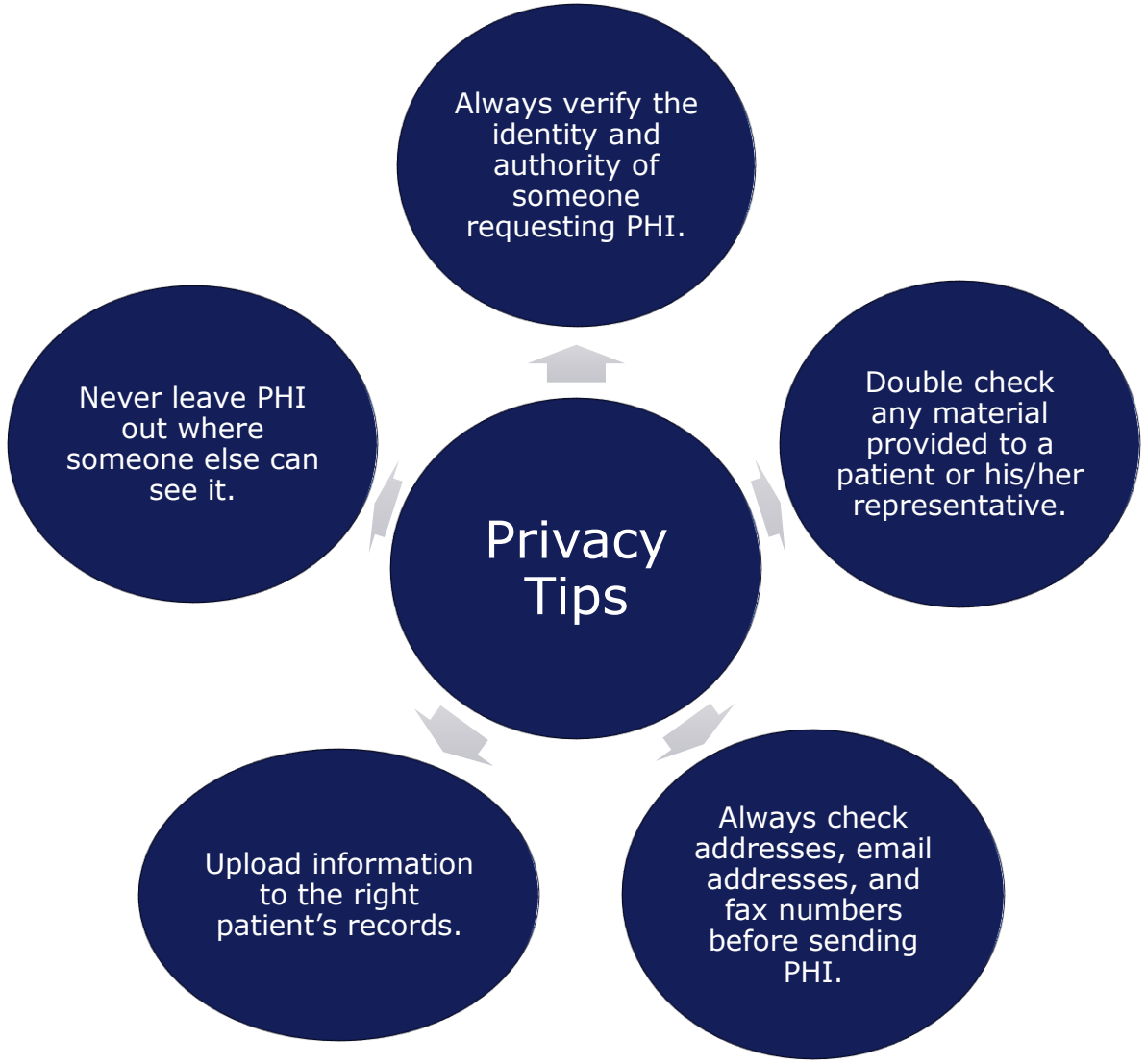
- Leaving your computer unlocked or PHI on your desk



- Not properly disposing of patient records (e.g. not shredding paper records)

- Gossiping about a patient's medical records

How to Support Our Patients' Privacy



How to Support Documentation, Coding and Billing Compliance

Why is it important?

- As a provider, you have an obligation to submit accurate and complete diagnosis data to support patient cost of care and ensure appropriate payment.

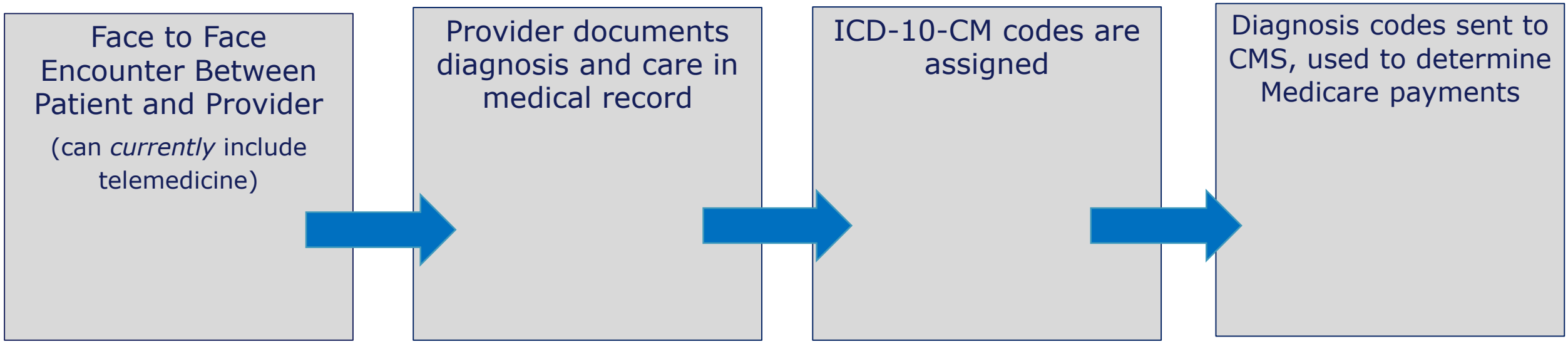
- Good documentation, billing and coding practices help to ensure patients receive appropriate care, allows other providers to rely on your records for patient medical histories, and helps prevent fraud, waste and abuse.

Accurate and complete documentation ensures appropriate patient care and management

Overlap with Medicare Risk Adjustment (MRA)

MRA is the model used to predict future health care costs based on demographics and patient diagnosis.

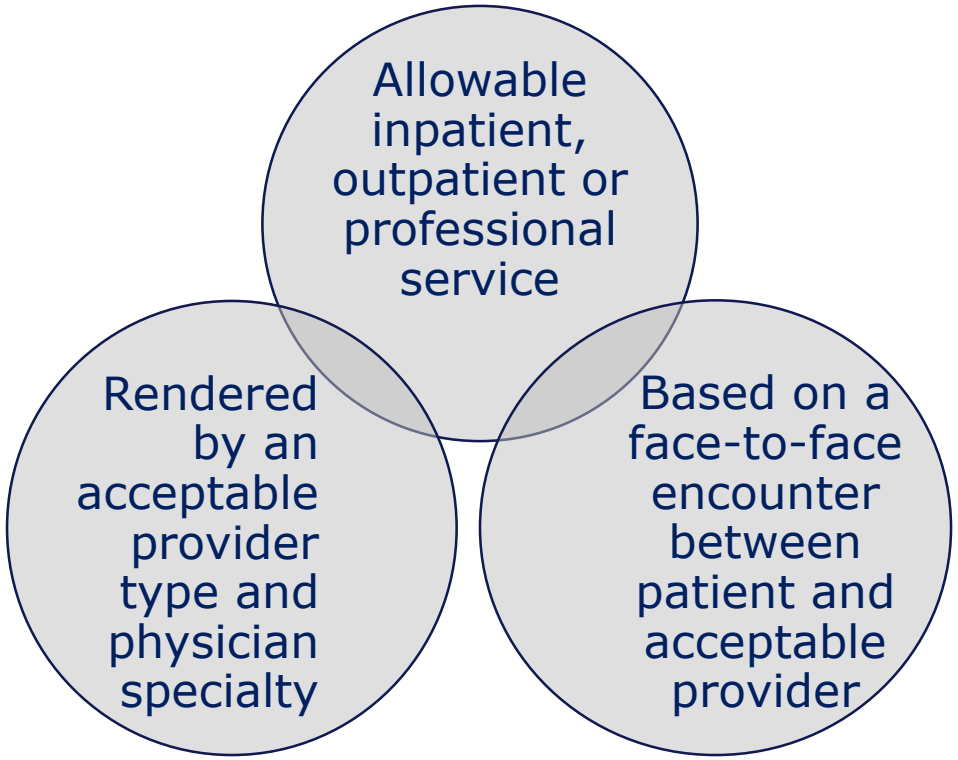
CMS uses Medicare Risk Adjustment to determine the rates paid to Medicare Advantage plans.



MRA: Applicability of diagnoses from telehealth services

As a result of the 2020 COVID-19 pandemic, CMS released **new guidance** regarding **risk adjustment data** submissions from telehealth services.

Medicare Advantage Organizations (MAOs) **may submit diagnoses for risk adjustment from telehealth encounters**, only when those encounters meet all criteria for risk adjustment data submission, including:



This guidance applies to eligible face-to-face telehealth encounters using a real-time interactive audio and video telecommunication platform within open data submission periods, which include 2019 and 2020 dates of services (DOS).

April 10, 2020 CMS HPMS Memo; April 29, 2020 CMS Stakeholder Call

Documentation, Coding and Billing Standards

Documentation

- Complete medical record documentation as soon as possible after patient visit
- Maintain accurate and complete records and promptly close progress notes, preferably during the visit

Coding

- If you are responsible for coding:
- select codes that best reflect the documented diagnosis and service rendered
- "default coding" to a particular billing code should never be used

Billing

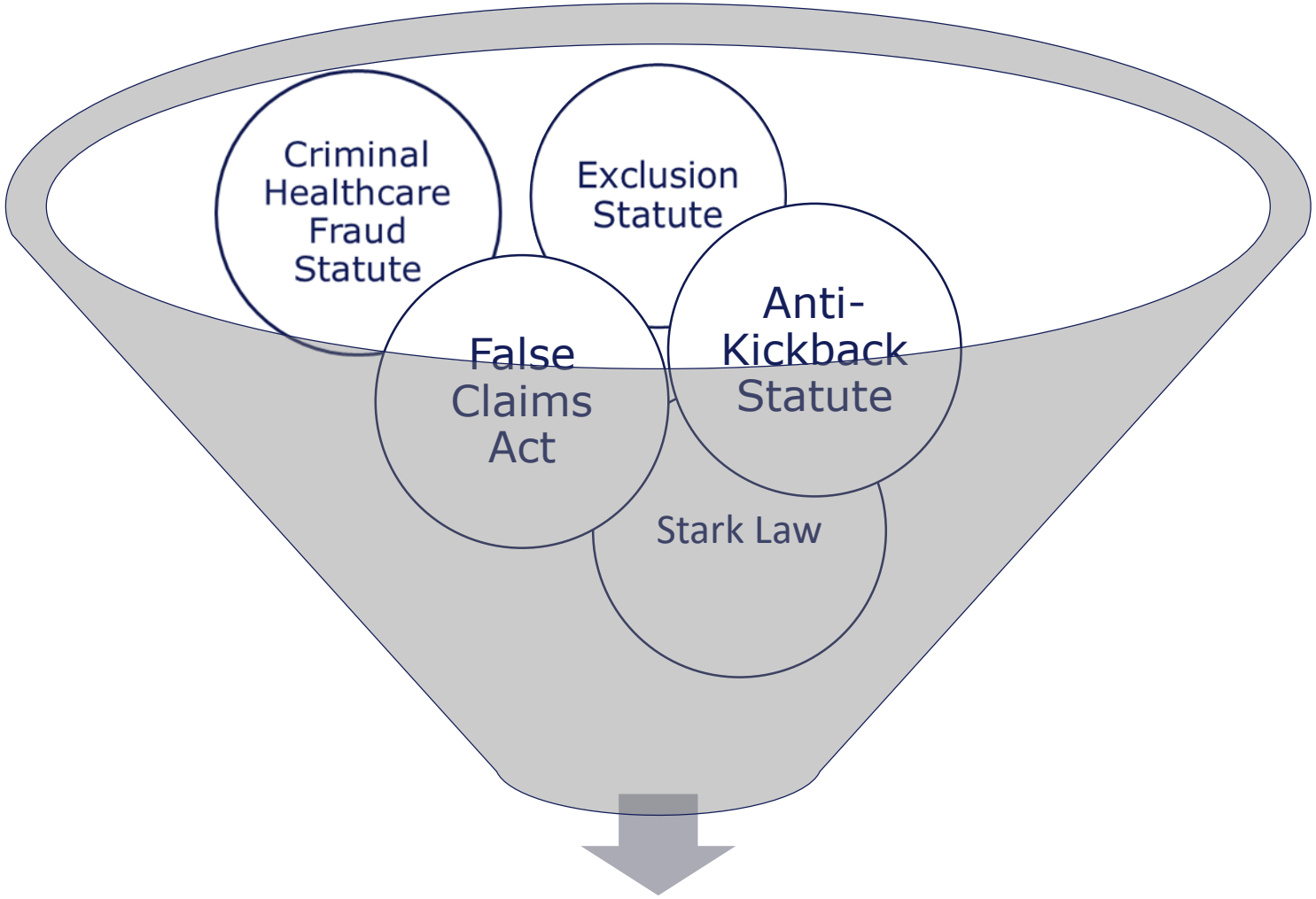
- Bills should only be submitted for actual services rendered
- Must always be based on documentation in the medical record

Audits and Investigations

- There may be periodic auditing and monitoring of billing, coding and documentation.
- Audits are intended to be a proactive measure to help identify risks and implement corrective action.
- If an audit uncovers more serious concerns, or a pattern of violations, an investigation may be launched.
- Participate, cooperate and be truthful in investigations.

Key Laws to Know

Laws Governing Healthcare Compliance



Together, these laws allow for civil prosecution, criminal conviction/fines, loss of license, imprisonment, and exclusion from Federal healthcare programs.

False Claims Act (FCA)

Overview:

- Originally enacted during the Civil War to address fraud in military procurement contracts
- Is intended to prevent fraud and recover losses involving any federally funded program
- Sets up penalties for "knowingly" submitting a false claim to the government for payment

Broad Knowledge Standard:

- "Knowingly" is broadly defined to mean:
  - Actual knowledge
  - Deliberate ignorance of the truth (shielded oneself from the truth)
  - Reckless disregard of the truth (should have known)

Penalties include fines of $22,000 or more for each false claim

False Claims Act (FCA)

Examples:

- Submitting multiple billing codes instead of one to increase reimbursement (i.e. unbundling)
- Billing for items/services not provided
- Failure to refund known Medicare and/or Medicaid Overpayments

If you are overpaid, report it immediately,
but no later than 60 days.

Stark Law and Anti-Kickback Statutes

	Stark Law (Physician Self-Referral Law)	Anti-Kickback Statute
Prohibits	Physicians from referring patients for designated health services to an entity which the physician has a financial interest.	Offering, paying soliciting or receiving anything of value to induce or reward referrals or generate Federal healthcare program business.
Referrals	From physicians	From anyone
Items/Services	Designated health services	Any items or services
Penalties	Fines, repayment of claims, and potential exclusion from participation in Federal healthcare programs.	Criminal penalties and administrative sanctions, including fines, imprisonment, and exclusion from Federal healthcare programs.
Intent	No intent required except when assessing civil monetary penalties.	Intent must be proved.
Examples	A physician refers a patient to a clinic where the doctor has an investment interest.	A physician receives cash or below-the-fair-market-value rent for medical office space in exchange for referrals.

Exclusion and Criminal Healthcare Statutes

	Exclusion Statute	Criminal Healthcare Fraud Statute
Description	Requires the Office of Inspector General (OIG) to exclude individuals and entities convicted of certain offenses from participation in Federal healthcare programs: • Patient abuse or neglect • Felony convictions for other healthcare-related fraud, theft or financial misconduct • Medicare or Medicaid fraud	Knowingly and willfully executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either: • Defraud any healthcare program • Obtain any of the money or property owned by, or under the control of, any healthcare program
Examples	Patient neglect Felony convictions	Several doctors and medical clinics conspire in a coordinated scheme to defraud Medicare by submitting medically unnecessary claims for power wheelchairs.
Penalties	Exclusion from participating in Federal healthcare programs, including Medicare and Medicaid.	Fines, imprisonment, or both.

Fraud, Waste and Abuse

The Notorious Trio		
Fraud **Intentionally carrying out a scheme to defraud** a healthcare program	**Waste** **Over-utilization of services** that directly or indirectly results in unnecessary costs	**Abuse** **Excessive or improper use of services** that leads to unnecessary costs

Examples of Fraud, Waste and Abuse

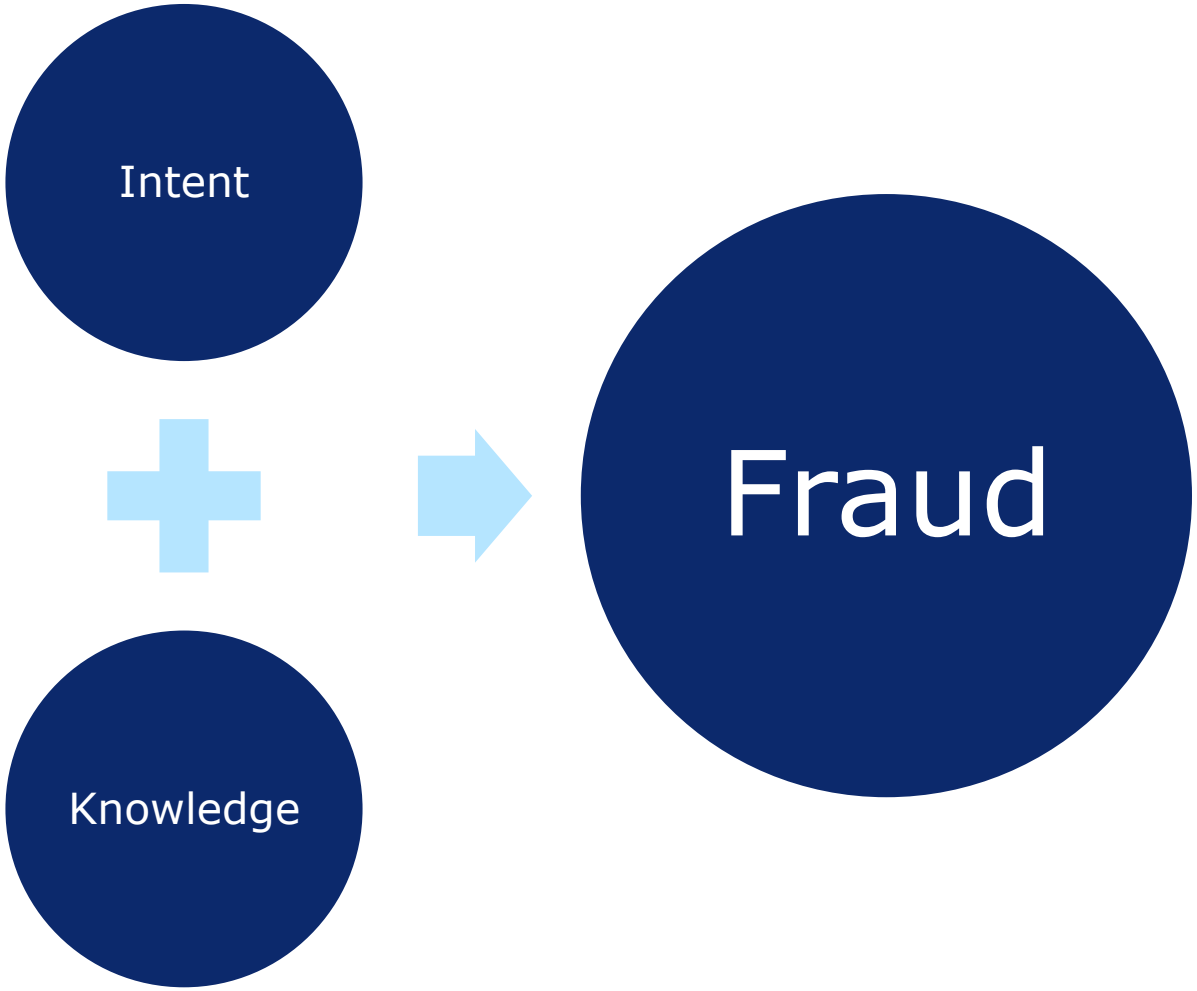
Fraud	• Intentionally billing for appointments that patients failed to keep • Intentionally billing for services not provided
Waste	• Ordering excessive diagnostic tests • Prescribing medications without validating the patient still needs them
Abuse	• Unknowingly misusing codes on a claim • Excessive charges for services or supplies

Fraud, Waste and Abuse Compared

The primary difference between fraud, waste and abuse is intent and knowledge

- **Fraud requires** the person to have **intent** to obtain payment and the **knowledge** that their actions are wrong

- **Waste and abuse** may involve an improper payment, but are **not accompanied by the same intent and knowledge**

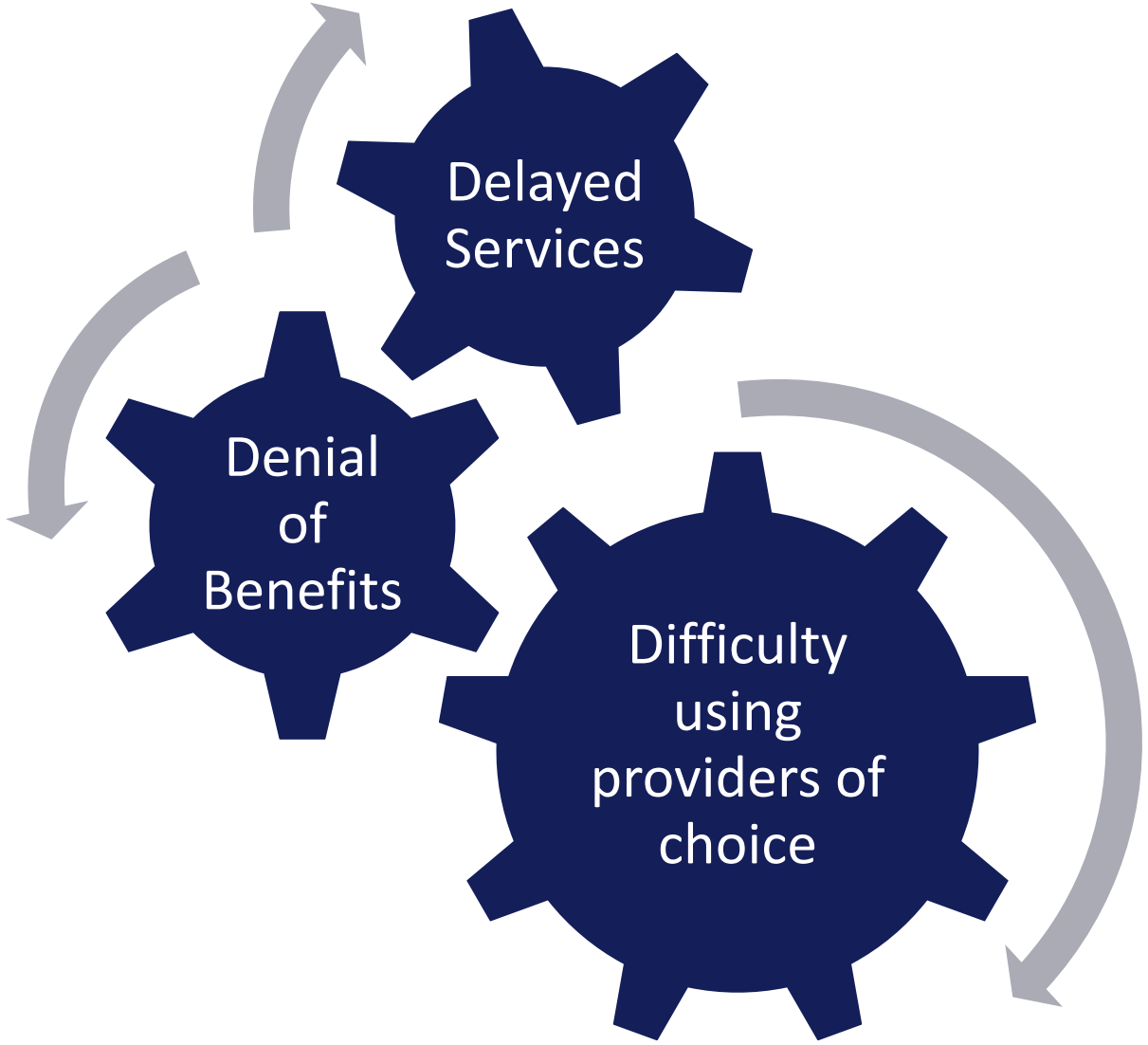


How Fraud, Waste and Abuse Stack Up

Consequences of Non-Compliance

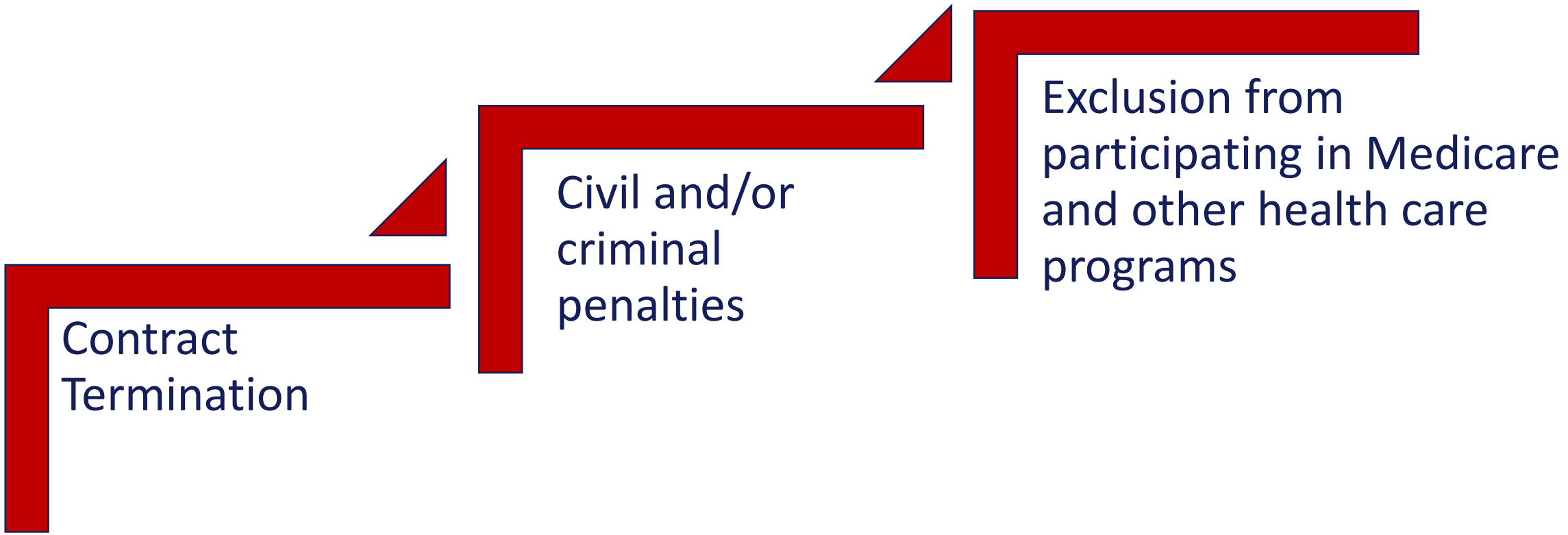
Non-Compliance Hurts Our Patients!

Fraud, waste, abuse and other forms of noncompliance jeopardizes our patients' access to and quality of care, and risks poorer health outcomes.



Personal Consequences

Engaging in non-compliant behavior can lead to serious personal consequences:



Reporting Concerns

How to Report Concerns

- We all have a responsibility to report any suspected misconduct or violations of the Code of Conduct, policies and procedures, laws, or regulations.

- CareMore has a strict non-retaliation policy to protect any employee, physician, contractor or volunteer when they report wrongdoing.