CareMore’s Compliance 101

GENERAL COMPLIANCE TRAINING FOR PROVIDERS
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.

<table>
<thead>
<tr>
<th>Patient Fraud Examples</th>
<th>Provider Fraud Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using someone else’s insurance card</td>
<td>Intentionally assigning a more severe diagnoses to inflate reimbursement</td>
</tr>
<tr>
<td>Forging or altering bills or receipts</td>
<td>Intentionally billing codes for a more expensive treatment than was provided</td>
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</table>
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

Prevent

Monitor/Audit

Detect

Correct

Report
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

- Social Security Number
- Address
- Telephone Number
- Health Plan ID Number
- Name
- Email Address
Patient Privacy Rights

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

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 Access

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

- 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
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
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.

<table>
<thead>
<tr>
<th>Area</th>
<th>PHI Permitted Use/Disclosure</th>
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<tbody>
<tr>
<td>Treatment</td>
<td>Treating patients, referring patients, and coordinating care</td>
</tr>
<tr>
<td></td>
<td>Submitting prescriptions</td>
</tr>
<tr>
<td>Payment</td>
<td>Pre-certifying procedures, billing premiums, and reimbursement</td>
</tr>
<tr>
<td></td>
<td>Paying claims</td>
</tr>
<tr>
<td>Operations</td>
<td>Answering patient calls, providing case management</td>
</tr>
<tr>
<td></td>
<td>Responding to an audit</td>
</tr>
<tr>
<td></td>
<td>Performing quality assurance</td>
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</table>
Common Privacy Violations

- Looking at your friends or family’s medical records
- Not properly disposing of patient records (e.g. not shredding paper records)
- Leaving your computer unlocked or PHI on your desk
- Gossiping about a patient’s medical records

Unauthorized Access of Files

Leaving information Unattended

Unauthorized Sharing of Information

Improper Disposal
How to Support Our Patients’ Privacy

Privacy Tips

- Always verify the identity and authority of someone requesting PHI.
- Never leave PHI out where someone else can see it.
- Double check any material provided to a patient or his/her representative.
- Upload information to the right patient’s records.
- Always check addresses, email addresses, and fax numbers before sending PHI.

Company Confidential
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*
# 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
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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Exclusion Statute</th>
<th>Criminal Healthcare Fraud Statute</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Requires the Office of Inspector General (OIG) to exclude individuals and entities convicted of certain offenses from participation in Federal healthcare programs:</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Patient abuse or neglect</td>
<td>• Defraud any healthcare program</td>
</tr>
<tr>
<td></td>
<td>• Felony convictions for other healthcare-related fraud, theft or financial misconduct</td>
<td>• Obtain any of the money or property owned by, or under the control of, any healthcare program</td>
</tr>
<tr>
<td></td>
<td>• Medicare or Medicaid fraud</td>
<td></td>
</tr>
<tr>
<td>Examples</td>
<td>Patient neglect</td>
<td>Several doctors and medical clinics conspire in a coordinated scheme to defraud Medicare by submitting medically unnecessary claims for power wheelchairs.</td>
</tr>
<tr>
<td></td>
<td>Felony convictions</td>
<td></td>
</tr>
<tr>
<td>Penalties</td>
<td>Exclusion from participating in Federal healthcare programs, including Medicare and Medicaid.</td>
<td>Fines, imprisonment, or both.</td>
</tr>
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</table>
# Fraud, Waste and Abuse

## The Notorious Trio

<table>
<thead>
<tr>
<th>Fraud</th>
<th>Waste</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentionally carrying out a scheme to defraud a healthcare program</td>
<td>Over-utilization of services that directly or indirectly results in unnecessary costs</td>
<td>Excessive or improper use of services that leads to unnecessary costs</td>
</tr>
</tbody>
</table>
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

- Mistakes Result in Errors
- Inefficiencies Result in Waste
- Bending the Rules Results in Abuse
- Intentional Deception Results in Fraud
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.

- Delayed Services
- Denial of Benefits
- Difficulty using providers of choice
Personal Consequences

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

- Contract Termination
- Civil and/or criminal penalties
- Exclusion from participating in Medicare and other health care programs
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.

E-mail: EthicsAndCompliance@anthem.com

In Person: ECP Associate

Reporting Concerns
Anonymous and Confidential

Helpline: 1-877-725-2702

Website: AnthemEthicsHelpline.com

Mail: P.O. Box 791 Indianapolis, IN 46206