CareMore's Compliance 101

GENERAL COMPLIANCE TRAINING FOR PROVIDERS

LAST REVISED: SEPTEMBER 2022

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
- No Billing of Members ("Member Hold Harmless")
- Consequences of Non-Compliance

Reporting Concerns

- How to Report

CareMore HEALTH

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 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
- Provide you with resources to assist with day-to-day compliance questions

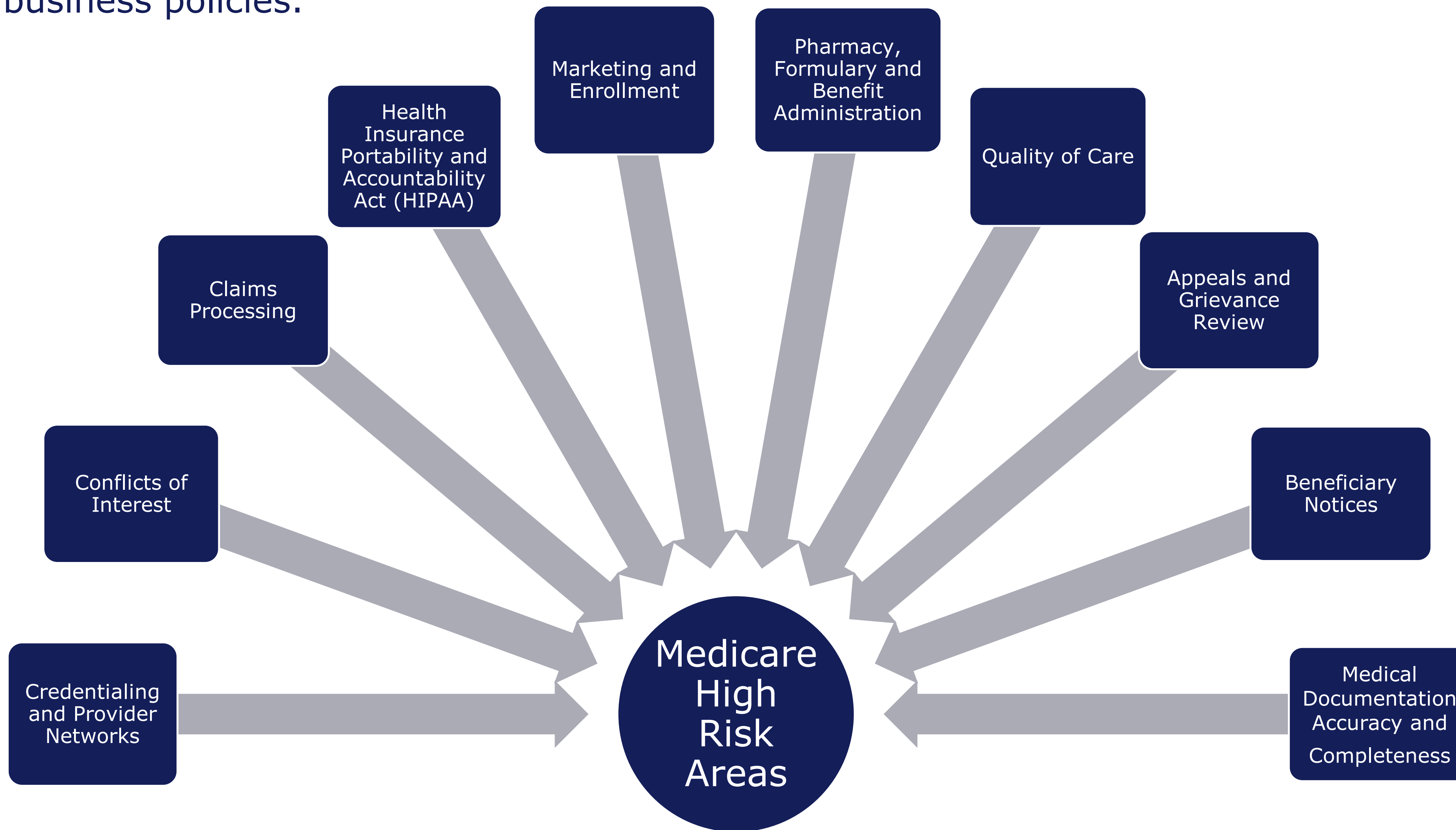
CareMore's Code of Conduct

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

Patient Fraud

- Using someone else's insurance card
- Forging or altering bills or receipts
- Obtaining medications to give to a friend or family member

Provider Fraud

- Intentionally assigning a more severe diagnosis code to inflate reimbursement
- Intentionally billing codes for a more expensive treatment than was provided
- Documenting on a patient's chart who was never seen
- Providing medically unnecessary services
- Billing for services not performed

Non-Compliance Isn't Always Intentional

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

- Mount Sinai St. Luke's was hit with a $2.5M lawsuit after accidentally faxing a patient's HIV status to his workplace.
- The man had provided specific instructions to mail the information to his post office box, but instead a fax was sent to his office mailroom.
- The documents faxed contained not only his HIV status, but previous diagnoses for sexually-transmitted diseases, history of physical abuse, sexual orientation information, mental health information, and social security number.
- The man had not yet disclosed his HIV status to many of his friends and family. The stress of the event led to him quitting his job, and loosing health insurance.

Roles and Responsibilities

CareMore’s Role in Compliance

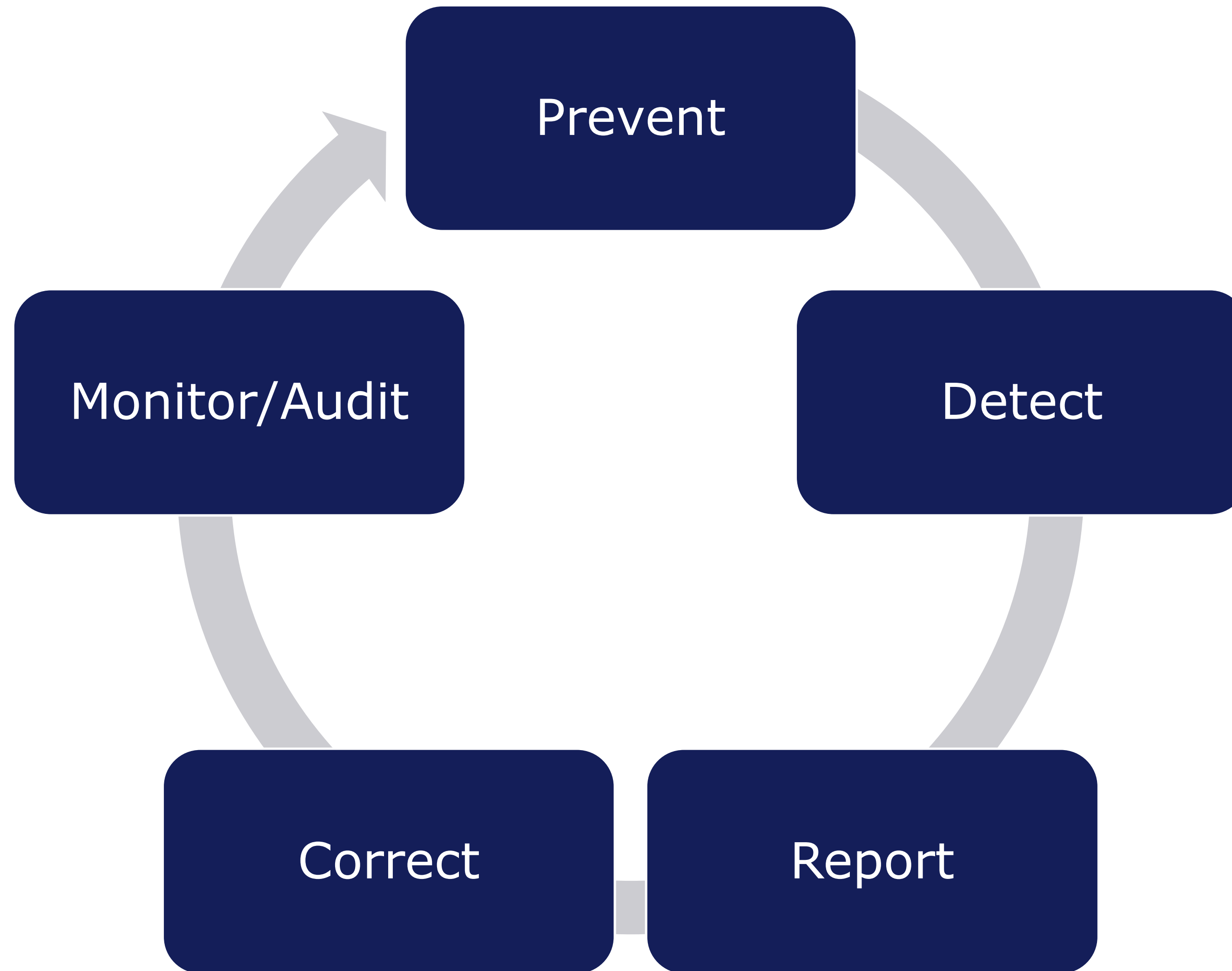
CareMore has implemented a compliance program to help detect and prevent violations, both big and small.

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

Report concerns

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 or activity which may influence, or appear to influence, your ability to act in CareMore's best interest.

- Examples of a potential COI:
  - Board participation
  - Political activities
  - Family member working for Elevance Health
  - Working part-time for another medical facility or provider

If you are uncertain whether a conflict exists, reach out to Ethics at ConflictofInterest@elevancehealth.com

Conflicts of Interest (COI), Cont.

- Associates must complete a Conflict of Interest (COI) disclosure w/in 30 days of hire
- When job responsibilities, outside activities, or personal relationships change, associates are required to disclose any potential COIs immediately
- Associates may not own, directly or indirectly, a significant financial interest in any company that does business with CareMore/Aspire, seeks to do business with them, or competes with them
- Associates may not refer patients to a company they, or a family member, has a financial interest

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 includes:
    - 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

Name

Telephone Number

Health Plan ID Number

Email Address

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 generally prohibited. Please reach out Legal or Privacy for exceptions.
- 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

Audits, Fines, and Sanctions

Loss of Patient Trust

Risk of Identity Theft

Harm to Our Reputation

What Can We Disclose?

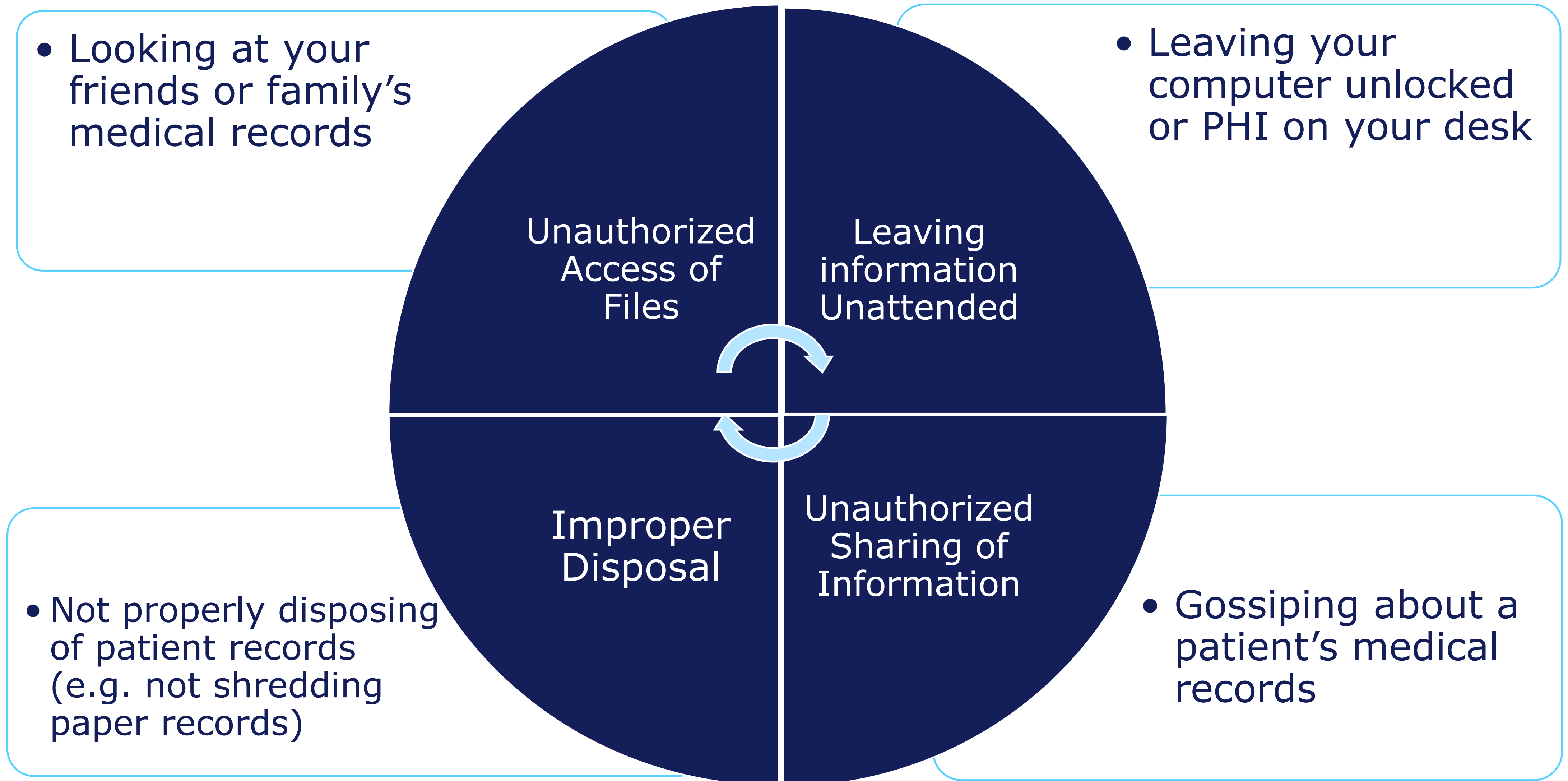
The minimum amount of PHI necessary for patient treatment, payment, and other activities related to care.

PHI Disclosure

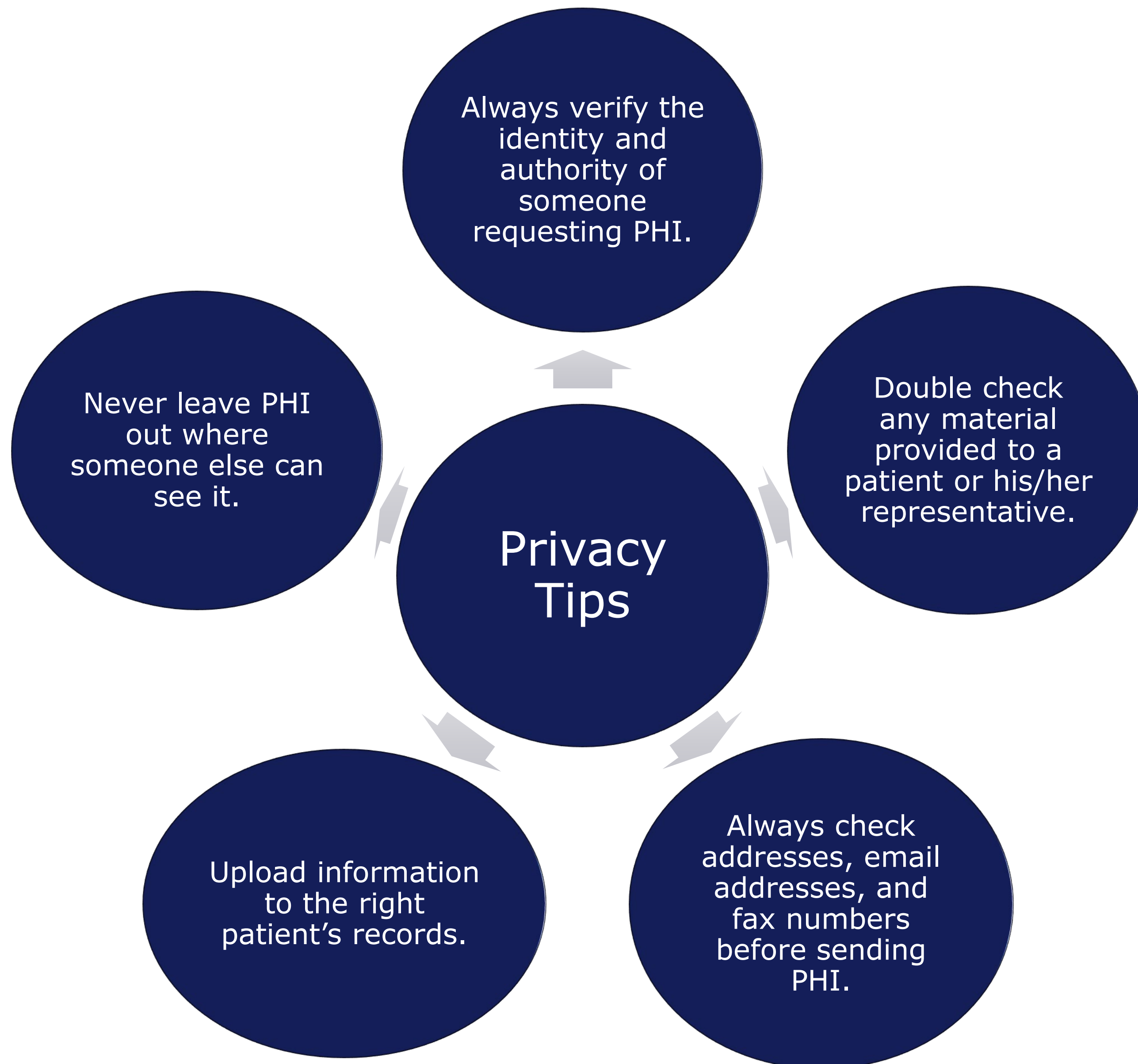
Under certain circumstances, PHI may be used or disclosed without first obtaining patient authorization, but always remember to provide the **minimal amount** of information needed to do the job.

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



How to Support Our Patients' Privacy



All actual and suspected unauthorized disclosures of PHI should be immediately reported to Privacy@caremore.com.

How to Support Documentation, Coding and Billing Compliance

Why is it important?

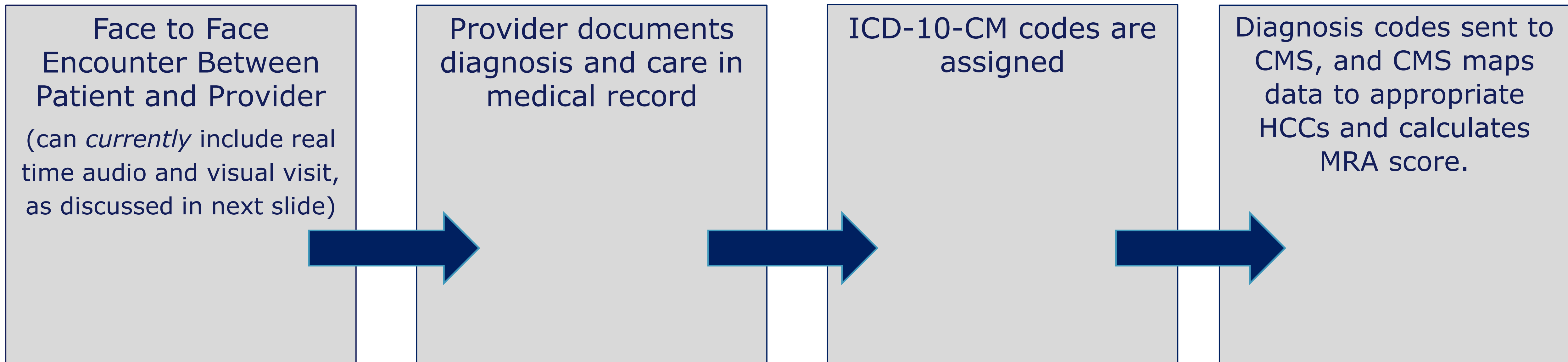
- As a provider, you have an obligation to submit accurate and complete diagnosis data to support patient cost of care and ensure appropriate payment.
- Good documentation, billing and coding practices help to ensure patients receive appropriate care, allows other providers to rely on your records for 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.

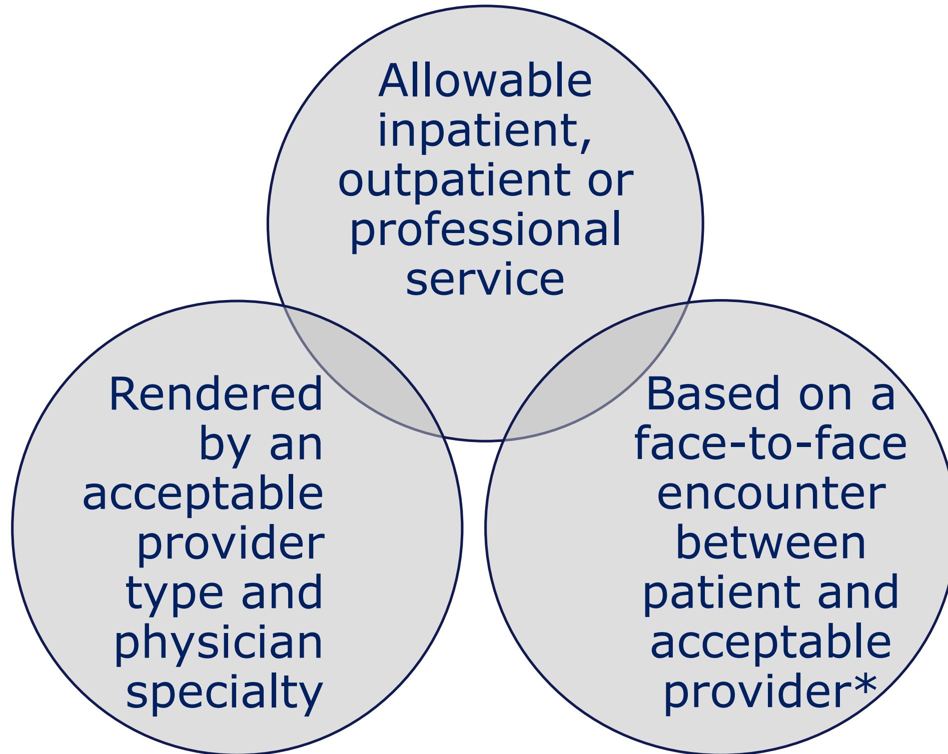
CMS uses Medicare Risk Adjustment to determine the rates paid to Medicare Advantage plans.



MRA: Applicability of diagnoses from telehealth services

As a result of the COVID-19 Public Health Emergency, CMS released **guidance** regarding **risk adjustment data** submissions from telehealth services.

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



*Face-to-face telehealth encounters are those using interactive audio simultaneously with video to permit real-time communication. An audio-only encounter is not acceptable for risk adjustment purposes. This guidance is applicable to open data submission periods, which to date include 2019, 2020, 2021, and 2022 dates of services (DOS).

April 10, 2020 CMS Memo; April 29, 2020 CMS Stakeholder Call; January 15, 2021 CMS Memo

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

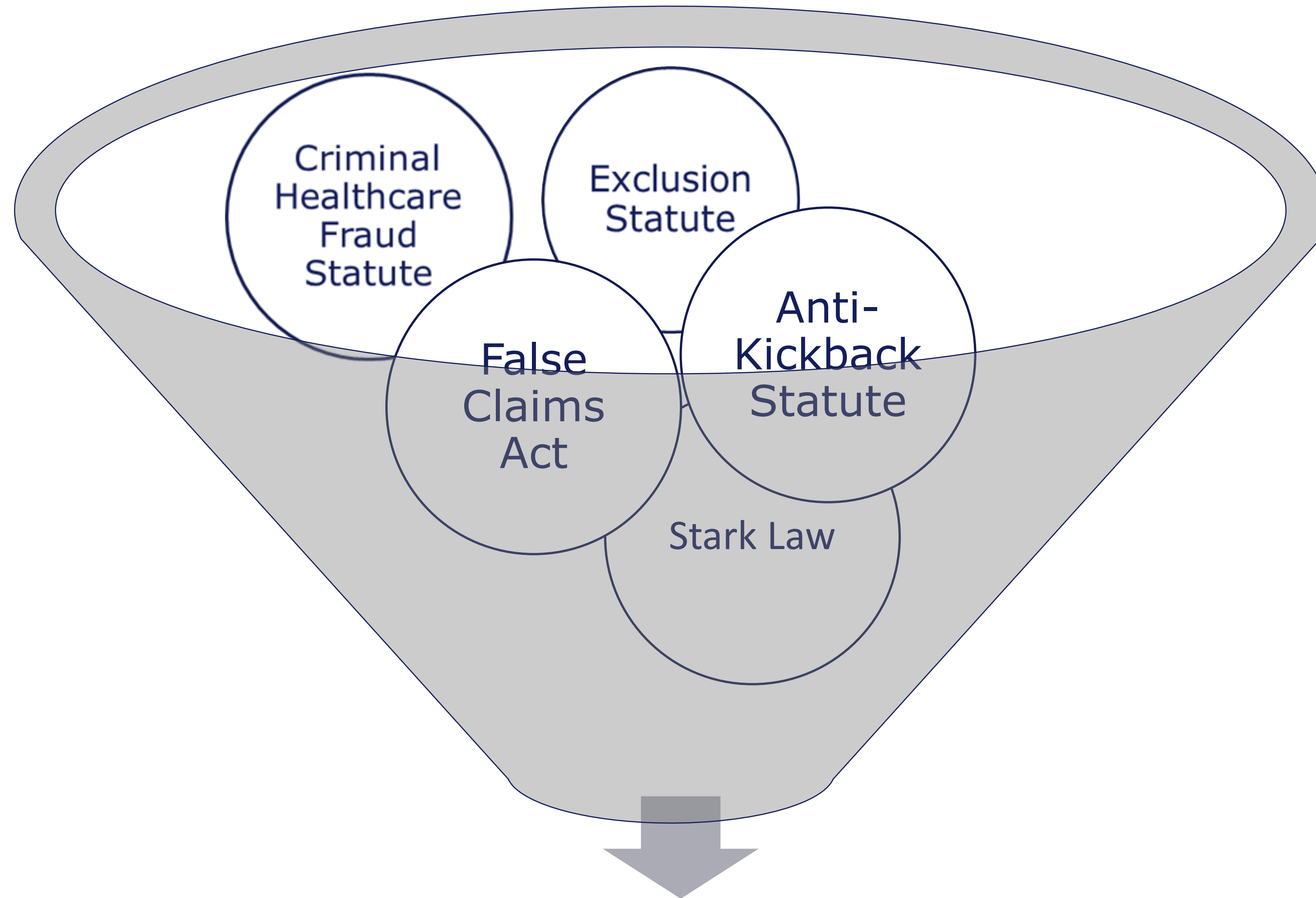
- Bills should only be submitted for actual services rendered
- Must always be based on documentation in the medical record

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 civil penalties of $22,000 or more per claim, injunctive relief, exclusion from Medicare programs. Civil cases can also be prosecuted criminally, resulting in imprisonment and fines.

False Claims Act (FCA)

Examples:

- Submitting bills to an MAO for a patient encounter that did not occur.
- Submitting bills to an MAO (i) for services not provided or (ii) that report conditions not documented in the medical record for the visit.
- Documenting diagnoses in a patient's medical record that they do not have.
- Failing to notify an MAO if a previously submitted diagnosis code is determined to have been submitted in error.

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, unless an exception applies.	Offering, paying soliciting or receiving anything of value to induce or reward referrals or generate Federal healthcare program business, unless a Safe Harbor provision applies.
Referrals	From physicians	From anyone (i.e., not limited to physicians)
Items/Services	Designated health services (DHS)	Any items or services (can include anything of value)
Penalties	Fines, repayment of claims, and potential exclusion from participation in Federal healthcare programs.	Criminal penalties (including jail time) and administrative sanctions, including fines, imprisonment, and exclusion from Federal healthcare programs.
Intent	No intent required except when assessing civil monetary penalties.	Intent to facilitate the referral must be proved.
Examples	Tuomey Healthcare System was subject to a $237M judgement for requiring physicians to refer their outpatient procedures to Tuomey in exchange for bribes.	Collier and Tampa Pain were ordered to pay over $1.6M when they engaged in a kickback scheme whereby they caused ambulatory surgery centers (ASCs) to routinely waive the facility fee copayments for patients to induce these patients to select the ASCs (and the particular physician who owned Collier) for their pain injection procedures.

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

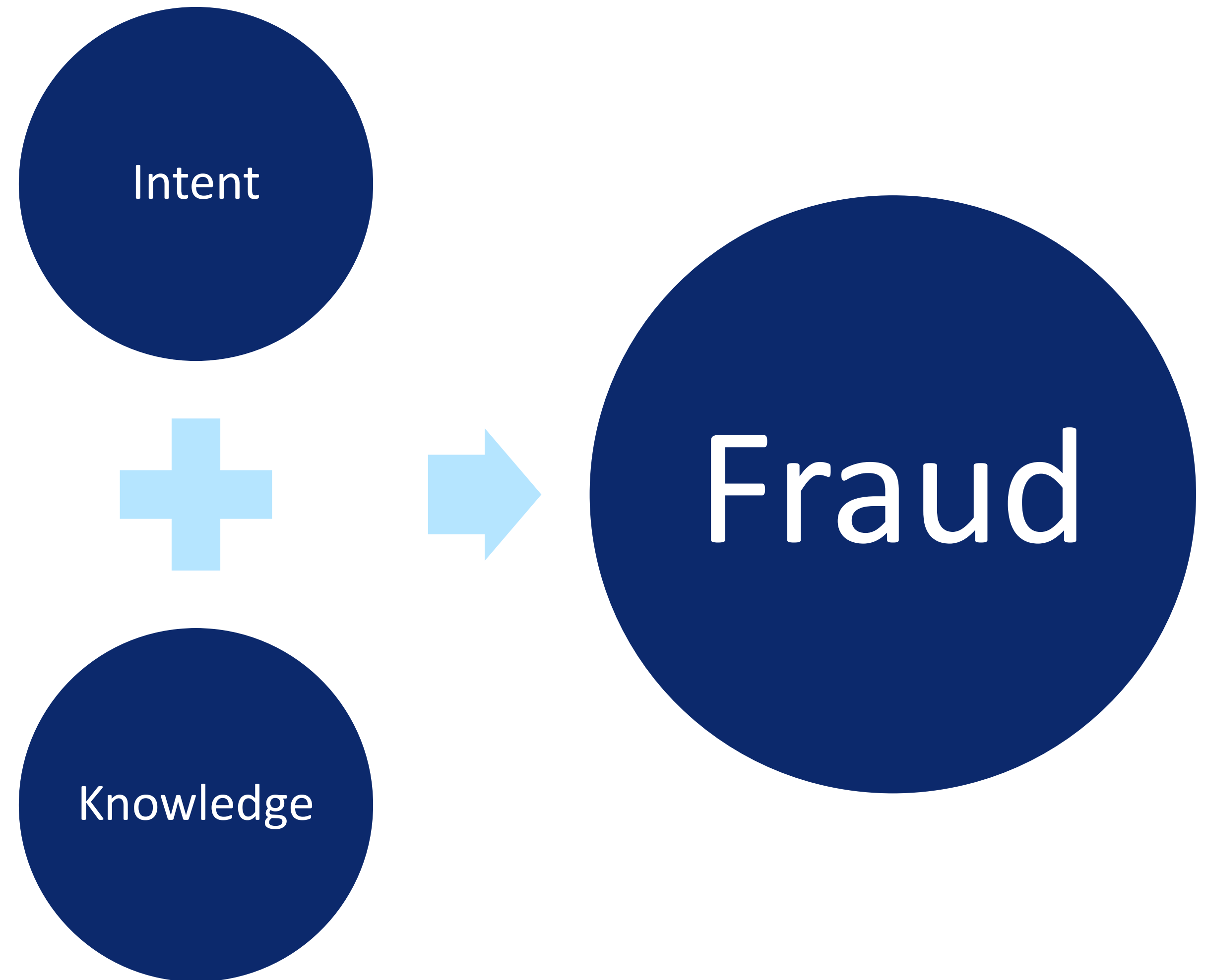
Examples of Fraud, Waste and Abuse

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

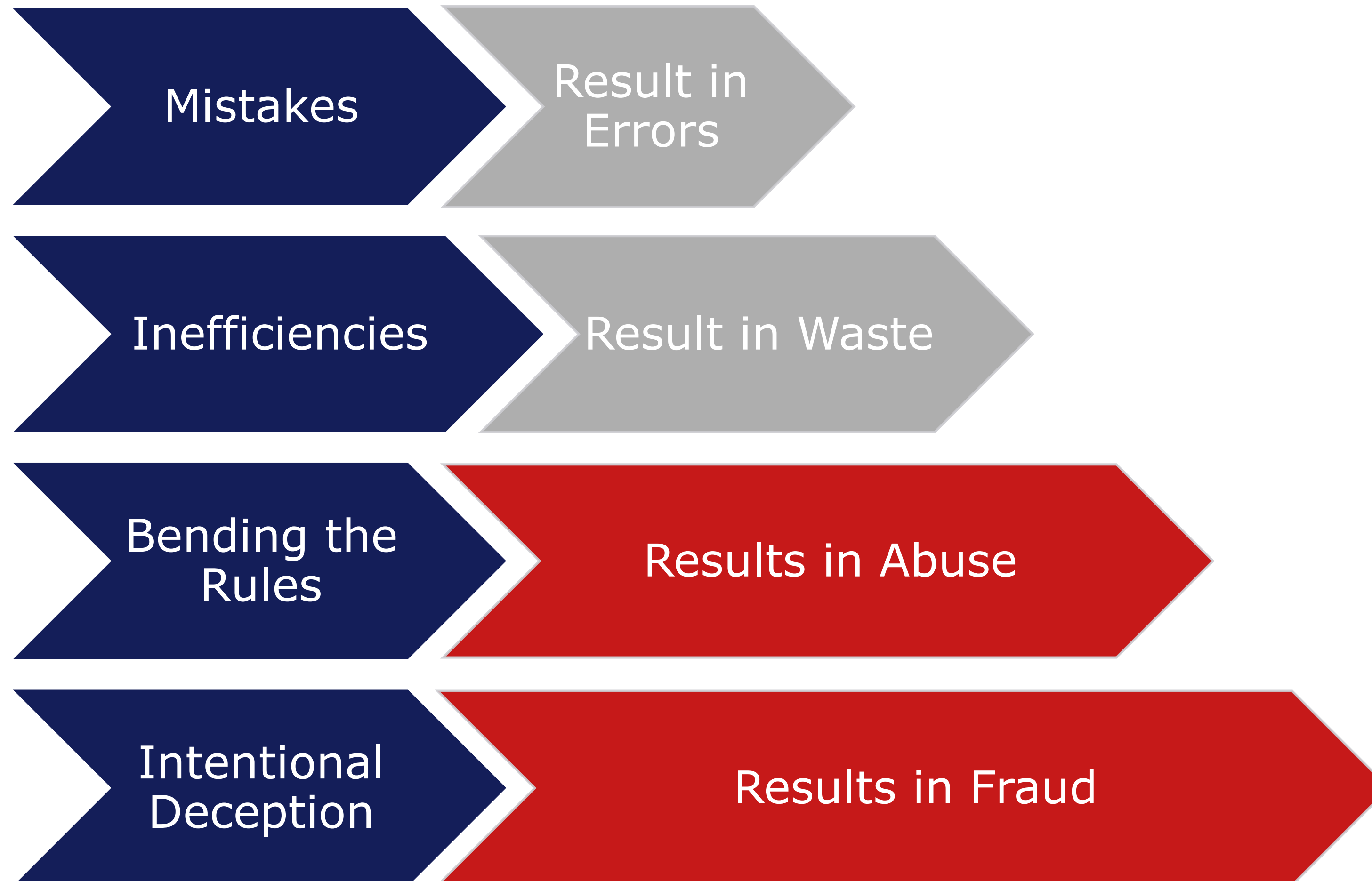
Fraud, Waste and Abuse Compared

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



Balance Billing

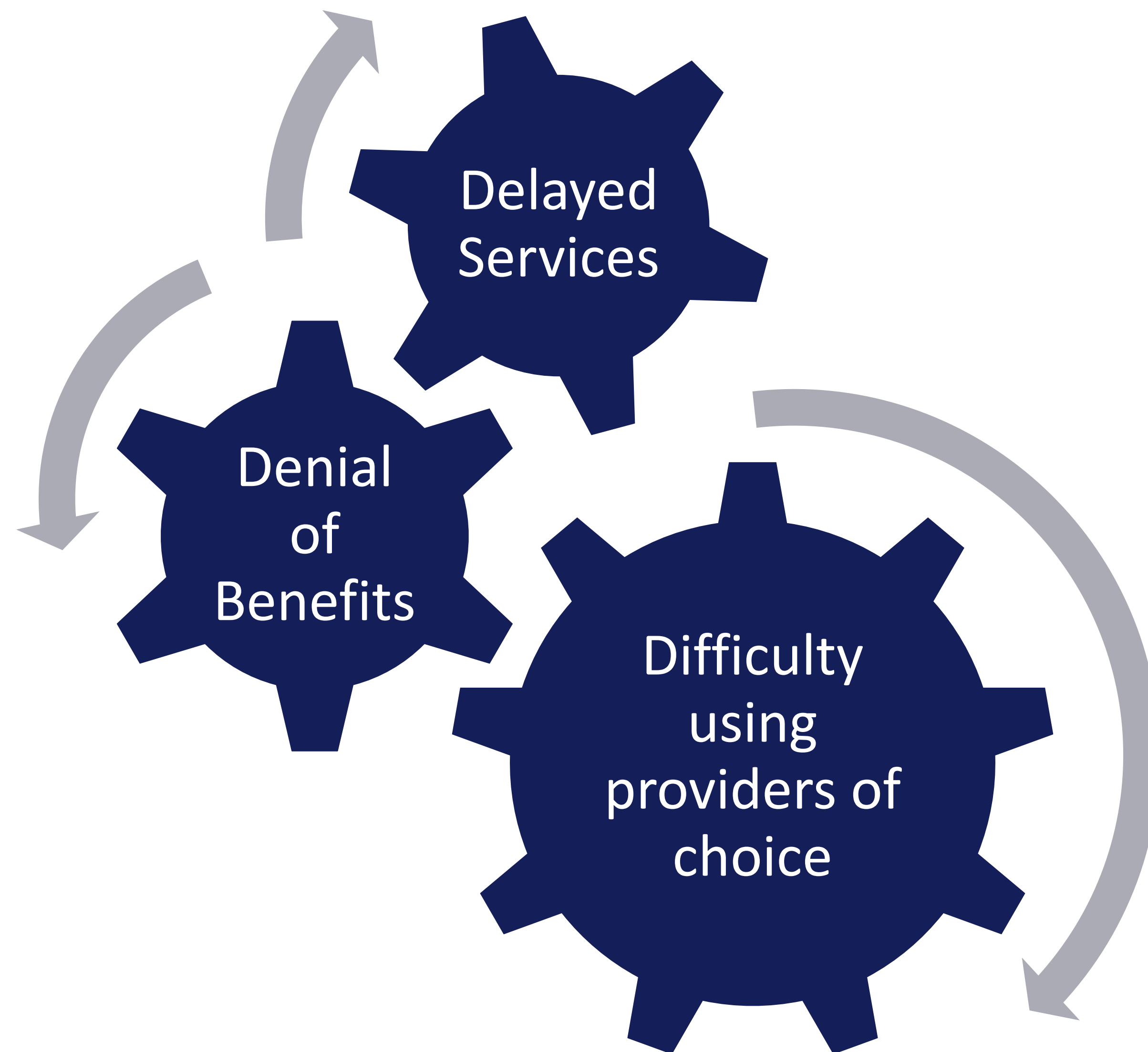
Per CMS, providers are prohibited from billing members the difference between the provider's fee and payment made by the health plan. Providers are also prohibited from taking action against a member to collect money owed by Caremore to the provider.

- Consequences of balance billing include termination of a Provider Services Agreement.
- CareMore may also take other action, such as requiring the provider to return all unauthorized charges collected through balance billing.
- Provider's obligations under balance billing prohibitions will survive the termination of the Provider Services Agreement.

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.
- Should you need to report a privacy incident, email Privacy@caremore.com.
- CareMore has a strict non-retaliation policy to protect any employee, physician, contractor or volunteer when they report wrongdoing.