2023 Training and Education

General Compliance

Fraud Waste and Abuse

HIPAA

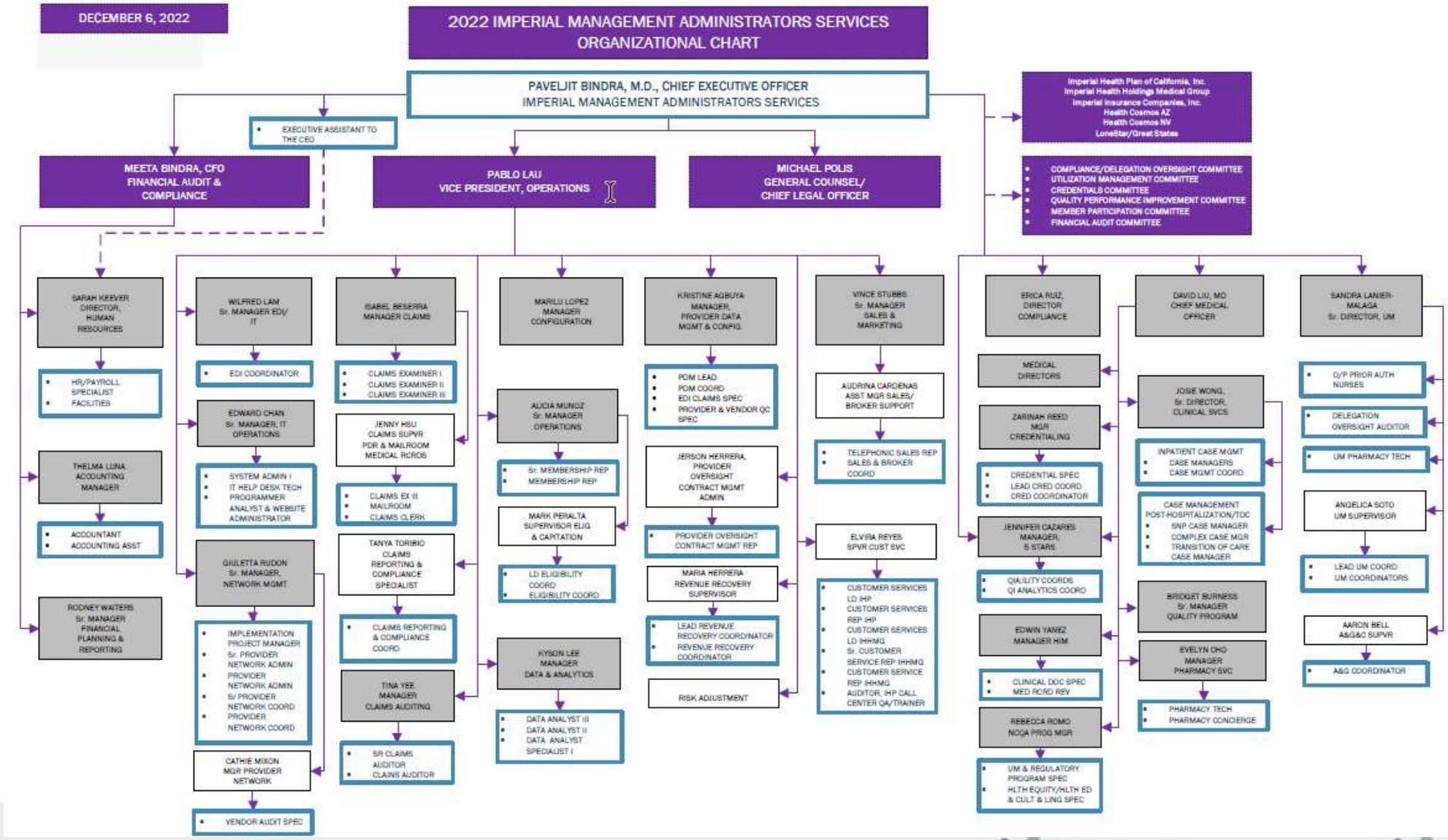
Imperial Health Plan of California

Imperial Insurance Companies

2023 Training and Education Table of Contents

Who is Imperial - Table of Contents

Organizational Structure – H5496 & H2793



IMPERIAL HEALTH PLAN OF CALIFORNIA

IMPERIAL INSURANCE COMPANIES

Service Area – H5496 & H2793

H5496 - Imperial Health Plan of California (HMO) (HMO SNP) - 2023
Plan Effective: 01/01/2018

Plan Name	Imperial Senior Value (HMO C-SNP) 005	Imperial Traditional (HMO) 007	Imperial Dual Plan (HMO D-SNP) 011	Imperial Dynamic Plan (HMO) 012	Imperial Strong (HMO) 014	Imperial Courage Plan (HMO) - 016
Service Area	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura, Yolo Amador, Butte, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Marin, Mariposa, Mendocino, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Luis Obispo, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Tehama, Tuolumne, Yuba	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura, Yolo Amador, Butte, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Marin, Mariposa, Mendocino, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Luis Obispo, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Tehama, Tuolumne, Yuba	Alameda, Contra Costa, Fresno, Kern, Kings, Madera, Merced, Placer, Sacramento, San Francisco, San Joaquin, Santa Barbara, Stanislaus, Tulare, Ventura, Yolo	Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, Ventura Alameda, Amador, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Placer, Plumas, Sacramento, Santa, Barbara, San Benito, Santa Clara, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, Tulare, Tuolumne, Yolo, Yuba	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura, Yolo Amador, Butte, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Marin, Mariposa, Mendocino, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Luis Obispo, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Tehama, Tuolumne, Yuba	Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Stanislaus, Tulare, Ventura, Yolo Amador, Butte, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Marin, Mariposa, Mendocino, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Luis Obispo, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Tehama, Tuolumne, Yuba
Qualifications	Must have: Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes	-	**Must have**: both Medicare & Medicaid	-	Part B Buy Down - $85	Part C ONLY NO PART D Part B Buy Down - $75
Senior Savings	Yes	Yes	No	Yes	No	No

H2793 - Imperial Insurance Companies (HMO) (HMO SNP) - 2023
Plan Effective: 01/01/2019

Plan Name	Imperial Insurance Company Traditional (HMO) 003	Imperial Insurance Company Dual (HMO D-SNP) 004	Imperial Insurance Value (HMO C-SNP) 005	Imperial Insurance Traditional Plus (HMO) 007	Imperial Courage Plan (HMO) - 008
Service Area	**Texas:** Bexar, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Harris, Hays, Montgomery, Nueces, Tarrant, Travis, Williamson**,** Wise	**Texas:** Bexar, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Harris, Hays, Montgomery, Nueces, Tarrant, Travis, Williamson**,** Wise	**Texas:** Bexar, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Harris, Hays, Montgomery, Nueces, Tarrant, Travis, Williamson**,** Wise	**Texas:** Bexar, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Harris, Hays, Montgomery, Nueces, Tarrant, Travis, Williamson**,** Wise	**Texas:** Bexar, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Harris, Hays, Montgomery, Nueces, Tarrant, Travis, Williamson**,** Wise
	Arizona: Coconino**,** Maricopa, Pima, Pinal, Yavapai **Nevada:** Clark		**Arizona:** Coconino**,** Maricopa, Pima, Pinal, Yavapai **Nevada:** Clark	**Arizona:** Coconino**,** Maricopa, Pima, Pinal, Yavapai **Nevada:** Clark	**Arizona:** Coconino, Maricopa, Pima, Pinal, Yavapai **Nevada:** Clark
Qualifications	-	**Must have**: both Medicare & Medicaid	**Must have**: Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes	Part B Buy Down - $110	Part C ONLY NO PART D Part B Buy Down - $75
Senior Savings	Yes	No	Yes	No	No

Red Font – New for 2023

Conflicts of Interest – IHHMG & H5496/H2793

- H5496/H2793 goes to the UM department and ask them to provide all the Anthem Blue Cross referral request
- H5496/H2793 ask A&G to provide a resolution for a similar grievance H5496/H2793 received
- H5496/H2793 Member Service Representative is at lunch at the patio. IHHMG joins H5496/H2793 Member Service Representative, and they start talking about a H5496/H2793 member
- IHHMG non-dual employee ask IT to give them access to the H5496/H2793 S drive
- IHHMG ask H5496/H2793 Sales team to provide the 2023 Summary of Benefit because Easy Choice Health Plan is asking for it
- IHHMG ask H5496/H2793 Compliance to review a P&P from Brand New Day
- IHHMG claims ask a non-dual employee to process an IHHMG claim
- H5496/H2793 and IHHMG sitting in the same room

Human Resources Vs Compliance Role

- Human Resources like any department have rules in regulation they must be to be compliant. Questions about Human Resources Compliance does not mean you go to Compliance to get the questions answered

Human Resources

- Employee Performance Review
- Employee Performance Improvement Plan
- Employee Handbook
- Employee Job Description
- Employee background check
- Enforce dress code
- Company cleanliness
- HR Policy and Procedure is incorrect

Compliance

- Audit and Monitoring
- Notice of Non-Compliance
- Compliance Program
- Employee Job Description is provided to CMS during an audit
- First Tier, Down Stream and Related entities (FDR)s exclusion list
- Enforce Federal Regulations
- FWA and HIPAA
- Where are Policy and Procedure stored in the shared drive

General Compliance Training - Table of Contents

Compliance Program Requirement

Mandatory Compliance Training

Upon hire and annually thereafter, the following is a condition of continued employment and included in the employee evaluations

- Fraud, Waste and Abuse Training (FWA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Compliance Program
- Code of Conduct

7 Core Compliance Program

CMS requires an effective compliance program to include seven core requirements:

1. Written Policies, Procedures, and Standards of Conduct These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.
2. Compliance Officer, Compliance Committee, and High-Level Oversight The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.
3. Effective Training and Education This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.
4. Effective Lines of Communication Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels.
5. Well-Publicized Disciplinary Standards Sponsor must enforce standards through well-publicized disciplinary guidelines.
6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program. NOTE: Sponsors must ensure FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.
7. Procedures and System for Prompt Response to Compliance Issues The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

What is Non-Compliance

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

Report Compliance Issues & FWA or Submit Questions

Report suspected or detected noncompliance

- Call at 1-888-708-5377
- Fax at 1-626-380-9054
- complianceFWA@imperialhealthplan.com
- Mail Attn: Compliance FWA
  PO Box 60874
  Pasadena, CA 91116
- Have a Compliance question or need clarification
- Compliance related questions or report of suspected or detected noncompliance or potential FWA are confidential anonymous and non-retaliation

What Are Internal Monitoring and Audits?

Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures. Below are internal audit areas Compliance reviews monthly:

A&G
- Part C Grievances
- Part D Grievances
- Reconsiderations – Part C Appeals
- Redeterminations – Part D Appeals

Health Services
- Organization Determinations Pre-Service (referral requests) and Post-Service (claims)
- Special Needs Plan (SNP) Management (Health Risk Assessment)

Claims
- Organization Determinations Post-Service (claims)
- Provider Disputes

Membership
- Enrollments
- Cancellations
- Dis-enrollments

Sales
- All documents submitted with the Enrollment Application

Provider Network
- Added and termed providers

Stay Informed About P&P

Every department and First-Tier, Downstream, and Related Entity (FDR) (IPA, MSO, Supplemental vendor etc.) must have P&P that address FWA. These procedures should help you detect, prevent, report, and correct FWA as well as HIPAA, Compliance, Standards of Conduct and operational P&Ps

Standards of Conduct P&Ps should describe the Sponsor's expectations that:

1. All employees conduct themselves in an ethical manner
2. Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
3. Reported issues will be addressed and corrected
4. Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom

You can locate Imperial Policy & Procedures (P&P)

- S:\Imperial Health Plan of California\P&Ps
- If you see there is a missing P&P let Compliance know

Standards of Conduct – Table of Contents

Code of Conduct

Code of Conduct that must be followed by all employees and that relates to Imperial's commitment to provide a safe and healthy work environment including:

- Equal Employment Opportunity
- Harassment and Discrimination
- Americans with Disabilities Act
- A Drug-Free Workplace
- Workplace Violence Prevention
- Standards of Workplace Conduct Regarding:
    - Dealing with Customers
    - Conflicts of Interest
    - Confidentiality
    - Use of Company Resources
    - Compliance with Laws and Regulations
    - Dealing with Government Officials and Public Employees
    - Dishonesty and Fraud

Code of Conduct – Continued

Imperial expects all Employees to make a personal commitment to follow the Code of Conduct:

- I will comply with the letter and spirit of all applicable federal, state and local laws and regulations.
- I am responsible for the integrity of my own actions.
- I may not justify a non-compliant, illegal, fraudulent, dishonest, or unethical act by claiming it was ordered or approved by another employee.
- I am aware that no employee, regardless of level or position, is ever authorized by Imperial to commit or direct another employee to commit a non-compliant, illegal, fraudulent, dishonest or unethical act.
- I am free to contact the Imperial Compliance Department, or the 24-hour Fraud and Abuse Compliance Hotline for guidance on the legality or ethics of any action under consideration or any action taken.
- I will favorably represent Imperial through my proper conduct.
- The full text of the Imperial Code of Conduct is available under separate cover.

Code of Conduct – Continued

The Code of Business Conduct is a critical component of a compliance plan. Imperial is committed to upholding the highest standards of integrity by following the Guiding Principles of Business Conduct, as follows:

- Be Fair and Responsive in Serving Our Customers
- Always Earn and Be Worthy of Our Customers' Trust
- Respect Fellow Employees and Reinforce the Power of Teamwork
- Demonstrate a Commitment to Ethical and Legal Conduct
- Maintain Our Business and Compliance Standards
- Continuously Strive to Improve What We Do and How We Do It

Code of Conduct – Continued

Imperial does not employ or contract with individuals who have been excluded by Medicare (or Medi-Cal). Additionally, Imperial Compliance Department reviews the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties Lists System (EPLS) prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

Various laws and regulations apply to the conduct of individuals, businesses, organizations, and industries. Just as there are laws to govern our personal lives there are also laws that govern our professional lives. All employees are expected to conduct themselves consistent with the law.

Imperial is in the business of providing and arranging for health care and prescription drug services for various government-sponsored and private health care programs. In this industry, laws and regulations exist for virtually every aspect of the transaction of business with Imperial, including, but not limited to Medicare Part C and Part D: financial reporting and solvency, contract terms and conditions, appeals and grievances, quality improvement, utilization management, marketing and sales, enrollment and disenrollment procedures, premium billing, and collection, claims adjudication and general business practices. Every employee is expected to comply with all applicable laws and regulations on the federal, state and local levels. All employees are under a continual obligation to familiarize themselves with the laws affecting their jobs and put forth their best efforts to follow the law. Particular care must be applied in the area of Medicare law, regulation and Program policy.

Business Ethics – Table of Contents

Ethics: Do the Right Thing!

As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!

- Act fairly and honestly
- Adhere to high ethical standards in all you do
- Comply with all applicable laws, regulations, and CMS requirements
- Report suspected violations

How Do You Know What Is Expected of You?

Now that you've read the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation?

Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct.

Reporting Standards of Conduct violations and suspected non-compliance is everyone's responsibility.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance

Conflict of Interest Disclosures

Many of the relationships discussed are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may be obligated to disclose their existence. Rules about disclosing and managing conflicts of interest come from a variety of sources, including grant funders, such as states, universities, and the National Institutes of Health (NIH), and from the U.S. Food and Drug Administration (FDA) when you submit data to support marketing approval for new drugs, devices, or biologics

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

Fraud, Waste, and Abuse (FWA) Part 1 – Table of Contents

Recognize FWA in the Medicare Program

Every year billions of dollars are improperly spent because of FWA. It affects everyone—including you. This training will help you detect, correct, and prevent FWA. You are part of the solution.

Combating FWA is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Fraud

Fraud is knowingly and 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.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000.

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

FWA Differences

Fraud

Fraud is knowingly and 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.
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In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit

Waste

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare 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

Abuse describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Examples of Medicare abuse include:

- *Billing for unnecessary medical services*
- *Charging excessively for services or supplies*
- *Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement*

Penalties: Medicare abuse can also expose providers to criminal and civil liability

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website.

Examples of FWA

Examples of actions that may constitute Medicare fraud include:

- 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 Examples of actions that may constitute Medicare waste include:
- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests
- Examples of actions that may constitute Medicare abuse include:
- 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

Penalties: Defrauding the Federal Government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties.

Understanding FWA

To detect FWA, you need to know the law.
The following pages provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law)
- Exclusion from all Federal health care programs
- Health Insurance Portability and Accountability Act (HIPAA)

Penalties: Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMP), exclusion from all Federal health care programs, and criminal and civil liability

Federal Civil False Claims Act (FCA)

The civil FCA, 31 United States Code (U.S.C.) Sections 3729–3733, protects the Federal Government from being overcharged or sold substandard goods or services. The civil FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government.

The terms "**knowing**" and "**knowingly**" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No specific intent to defraud is required to violate the civil FCA.

Examples: *A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than actually provided*

Penalties: Civil penalties for violating the civil FCA may include recovery of up to three times the amount of damages sustained by the Government as a result of the false claims, plus penalties up to $22,927 (in 2019) per false claim filed. Additionally, under the criminal FCA, 18 U.S.C. Section 287, individuals or entities may **face criminal penalties** for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both

Anti-Kickback Statute (AKS)

The AKS, 42 U.S.C. Section 1320a-7b(b), makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS

Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies

Example: A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals

Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the CMPL, penalties for violating the AKS may include three times the amount of the kickback, plus up to $100,000 (in 2018) per kickback

Whistleblower

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

Physician Self-Referral Law (Stark Law)

UM - The Physician Self-Referral Law, 42 U.S.C. Section 1395nn, often called the Stark Law, prohibits a physician from referring patients to receive “designated health services” payable by Medicare or Medicaid to an entity with which the physician or a member of the physician’s immediate family has a financial relationship, unless an exception applies

Example: A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest

Penalties: Penalties for physicians who violate the Stark Law may include fines, CMPs up to $24,478 (in 2018) for each service, repayment of claims, and potential exclusion from participation in the Federal health care programs

Criminal Health Care Fraud

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 or for life.

For more information, refer to 18 USC Section 1347.
Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both

Exclusion Statute

The Exclusion Statute, 42 U.S.C. Section 1320a-7, requires the OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

Civil Monetary Penalties Law (CMPL)

The CMPL, 42 U.S.C. Section 1320a-7a, authorizes OIG to seek CMPs and sometimes exclusion for a variety of health care fraud violations. Different amounts of penalties and assessments apply based on the type of violation. CMPs also may include an assessment of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received. Violations that may justify CMPs include:

Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
Violating the AKS
Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

Accurate Coding and billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. You exert significant influence over what services your patients get. You control the documentation describing services they receive, and your documentation serves as the basis for claims you submit. Generally, Medicare pays claims based solely on your representations in the claim's documents

EXAMPLES

A Medicare Part C plan in Florida:
Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS. Was informed by the outside company that certain diagnosis codes previously submitted to. Medicare were undocumented or unsupported. Failed to report the unsupported diagnosis codes to Medicare. Agreed to pay $22.6 million to settle FCA allegations.

The owner-operator of a medical clinic in California:
Used marketers to recruit individuals for medically unnecessary office visits. Promised free, medically unnecessary equipment or free food to entice individuals. Charged Medicare more than $1.7 million for the scheme. Was sentenced to 37 months in prison.

EXAMPLES

A Pennsylvania pharmacist:
Submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed
Pleaded guilty to health care fraud. Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owner of multiple Durable Medical Equipment (DME) companies in New York:
Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors Provided no DME to any beneficiaries as claimed Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid Pleaded guilty to one count of conspiracy to commit health care fraud

Examples When a Claim is Submitted

When a provider submits a claim for services provided to a Medicare beneficiary, the provider is filing a bill with the Federal Government and certifying they earned the payment requested and complied with the billing requirements. If the provider knew or should have known the submitted claim was false, then the attempt to collect payment is illegal

Examples of improper claims include:

- *Billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided*
- *Billing medically unnecessary services*
- *Billing services not provided*
- *Billing services performed by an improperly supervised or unqualified employee*
- *Billing services performed by an employee excluded from participation in the Federal health care programs*
- *Billing services of such low quality they are virtually worthless*
- *Billing separately for services already included in a global fee, like billing an evaluation and management service the day after surgery*

Free Samples

Many drug and biologic companies provide free product samples to physicians. It is legal to give these samples to patients free of charge, but it is illegal to sell the samples

The Federal Government has prosecuted physicians for billing Medicare for free samples. If a provider choose to accept free samples, the provider needs reliable systems in place to safely store the samples and ensure samples remain separate from the stock non-free items

Disciplinary Guidelines for Noncompliant or Fraudulent Behavior

Depending on the type or level of Noncompliant or fraudulent behavior can result in mandatory retraining, disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported

What happens if we don't follow any of the Compliance Program rules? In addition to penalties such as hefty fines and trade sanctions, other consequences of non-compliance with applicable laws can include:
Criminal Charges
Reputational woes
Loss of lucrative opportunities

Your Role in the Fight Against FWA Part 2 – Table of Contents

Where Do I Fit In?

As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier entity (Examples: Pharmacy Benefit Management [PBM]; IPA/MSO; dental vendor; vision vendor; telehealth vendor; Over the Counter vendor; hearing vendor; gym vendor; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
- Downstream entity (Examples: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

Where Do I Fit In? (continued)

- I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.
- The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
- Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

Where Do I Fit In? (continued)

- I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.
- The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
- Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

What Are Your Responsibilities?

- You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.
- FIRST, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- SECOND, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware.
- THIRD, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance
- Verify all received information

Report FWA

- Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
- Report any potential FWA concerns you have to your compliance department in one of the following ways. The compliance department will investigate and make the proper determination
  - Call at 1-888-708-5377
  - Fax at 1-626-380-9054
  - complianceFWA@imperialhealthplan.com
  - Compliance mailbox in the breakroom
  - Mail Attn: Compliance FWA
    PO Box 60874
    Pasadena, CA 91116
- Compliance related questions or report of suspected or detected noncompliance or potential FWA are confidential anonymous and non-retaliation
- When in doubt, call your Compliance Department or FWA Hotline

Reporting FWA Outside Your Organization

- If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS.
- Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government- directed investigation and civil or administrative litigation.
- When reporting suspected FWA, include:
  - Contact information for the information source, suspects, and witnesses
  - Alleged FWA details
  - Alleged Medicare rules violated
  - The suspect's history of compliance, education, training, and communication with your organization or other entities

Where to Report FWA

- Compliance Officer /Privacy Officer: Erica Ruiz, (562) 239-5675, eruiz@imperialhealthplan.com
- Prevent, Detect, & Report It
- Call: 888-708-5377
- Fax 626-380-9054
- Compliancefwa@implerialhelthplan.com
- Compliance mailbox in the breakroom
- HHS Office of Inspector General: Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950 Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.govOnline: Forms.OIG.hhs.gov/hotlineoperations/index.aspx For Medicare Parts C and D:
- Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379) For all other Federal health care programs:
- CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
- Medicare beneficiary website: Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/help-fight-medicare-fraud

Correcting FWA Issues

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action.
- Monitor corrective actions continuously to ensure effectiveness.

Corrective Action Examples

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

Key Indicators: Potential Beneficiary Issues

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present potential FWA issues. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D benefits to enrollees.

Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicators: Potential Provider & Pharmacy Issues

Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have their active and valid National Provider Identifier on it?
- Is the provider's diagnosis for the member supported in the medical record?

Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Key Indicators: Potential Sponsor Issues

- Does the Sponsor encourage or support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe the cost of benefits is one price, when the actual cost is higher?
- Does the Sponsor offer beneficiaries cash inducements to join the plan?
- Does the Sponsor use unlicensed agents?

Health Insurance Portability and Accountability Act (HIPAA) The Rules, Privacy, Security, Electronic Data Exchange (EDI) – Table of Contents

HIPAA Definitions

HIPAA is Health Insurance Portability & Accountability Act of 1996 (45 C.F.R. parts 160 & 164).

- Provides a framework for establishment of nationwide protection of patient confidentiality, security of electronic systems, and standards and requirements for electronic transmission of health information.

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

- Created or received by a health care provider, health plan, employer, or health care clearinghouse and that
- Relates to the past, present, or future physical or mental health or condition of an individual;
- Relates to the provision of health care to an individual
- The past, present or future payment for the provision of health care to an individual.

What Does PHI Include? Information in the health record, such as:

- Encounter/visit documentation
- Lab results
- Appointment dates/times
- Invoices
- Radiology films and reports
- History and physicals (H&Ps)
- Patient Identifiers

The Rules

Privacy Rule

- Privacy Rule went into effect April 14, 2003
- Privacy refers to protection of an individual's health care data
- Defines how patient information used and disclosed
- Gives patients privacy rights and more control over their own health information
- Outline's ways to safeguard Protected Health Information (PHI)

Security Rule

- Security (IT) regulations went into effect April 21, 2005
- Security means controlling:
  - Confidentiality of electronic protected health information (ePHI)
  - Storage of electronic protected health information (ePHI)
  - Access into electronic information

Electronic Data Exchange (EDI) Rule

- Defines transfer format of electronic information between providers and payers to carry out financial or administrative activities related to health care.
- Information includes coding, billing and insurance verification.
- Goal of using the same formats is to ultimately make billing process more efficient.

Why Comply With HIPAA?

- To show our commitment to protecting privacy
- As an employee, you are obligated to comply with [Insert Your Organization Name] privacy and security policies and procedures
- Our patients/members are placing their trust in us to preserve the privacy of their most sensitive and personal information
- Compliance is not an option, it is required.

If you choose not to follow the rules:

- You could be put at risk, including **personal** penalties and sanctions
- You could put [insert organization name] at risk, including financial and reputational harm

HIPAA Regulations

HIPAA Regulations require we protect our member's' PHI in all media including, but not limited to, PHI created, stored, or transmitted in/on the following media:

Verbal Discussions (i.e., in person or on the phone)

Written on paper (i.e., chart, progress notes, encounter forms, prescriptions, x-ray orders, referral forms and explanation of benefit (EOBs) forms

Computer Applications and Systems (i.e., electronic health record (EHR), Practice Management, Lab and X-Ray

Computer Hardware/Equipment (i.e., PCs, laptops, PDAs, pagers, fax machines, servers and cell phones

It's the law.

- To protect our reputation.
- To avoid potential withholding of federal Medicaid and Medicare funds.
- To build trust between providers and patients.

How are HIPAA Regulations Enforced?

1. **The Public**. The public is educated about their privacy rights and will not tolerate violations! They will take action.
2. **Office For Civil Rights (OCR).** The agency that enforces the privacy regulations providing guidance and monitoring compliance.
3. **Department of Justice (DOJ).** Agency involved in criminal privacy violations. Provides fines, penalties and imprisonment to offenders.

Who or What Protects PHI?

1. **Federal Government** protects PHI through HIPAA regulations

   Civil penalties up to $1,500,000/year for identical types of violations.

   Willful neglect violations are mandatory!

   Criminal penalties:

   $50,000 fine and 1 year prison for knowingly obtaining and wrongfully sharing information.

   $100,000 fine and 5 years prison for obtaining and disclosing through false pretenses.

   $250,000 fine and 10 years prison for obtaining and disclosing for commercial advantage, personal gain, or malicious harm.

2. **Our organization**, through the Notice of Privacy Practices (NPP).

3. **You,** by following our policies and procedures.

Almost done

1. Sign the 3 attestations
2. Complete the quiz
3. Return 3 attestations and quiz to

regulatorycompliance@imperialhealthplan.com