Health Network Solutions

Compliance Training

for Contracted Health Care Professionals

Revised 04/11/17

Introduction

HNS has developed a compliance program to establish a culture within the HNS network that promotes prevention, detection, and resolution of conduct that does not conform to federal and state law, federal, state, and private payor health care program requirements, and/or HNS' ethical and business policies.

The HNS Compliance Program requires HNS to provide compliance training to contracted health care professionals. Compliance training helps increase awareness of our legal environment and helps us detect and prevent violations of laws applicable to our industry.

CMS requires that the compliance training provided by organizations like HNS include certain specific information published by CMS. Accordingly, those slides are included in this training module at the end of HNS' Compliance Training. These slides are easily identified by the slide colors of blue and yellow.

Commitment to Compliance

Compliance is everyone's responsibility.

HNS is committed to conducting our business in accordance with the highest ethical standards and in accordance with federal and state laws and regulations that govern our industry.

HNS expects that same commitment from our contracted health care professionals.

HNS' Compliance Training

Education and training regarding the laws and regulations that govern the health care industry is essential to ensure compliance to those laws.

Consistent with compliance program guidance published by the OIG, HNS has developed compliance training (and these compliance policies) for contracted health care professionals. HNS' Compliance training shall be consistent with CMS Compliance Training Requirements and any training requirements required by HNS contracted healthcare plans.

A primary focus of HNS' Compliance training
is to ensure contracted health care professionals understand relevant laws and regulations laws so that instances of non-compliance
can be promptly identified and remediated.

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Limitations on HNS' Compliance Training

This training module provides general information regarding compliance, fraud, waste and abuse laws, HIPAA/HITECH laws, security awareness, and HNS' compliance policies.

Neither the content of this training module nor the information in this section of this website are offered as, or constitute, legal advice. No one should rely on this training module, information included on the HNS website, or information obtained from HNS representatives, without first seeking appropriate professional legal advice.

HNS makes no claim, promise, or guarantee of any kind about the accuracy, completeness, or adequacy of the content of the presentation and expressly disclaims liability for errors and omissions in such content.

Goals of Compliance Training

The goals of HNS' compliance training are to:

- **Promote ethical conduct and business practices;**
- **Help you understand your compliance responsibilities as an HNS contracted health care professional;**
- **Help ensure your familiarity and compliance with HIPAA and HITECH laws and regulations and fraud, waste and abuse (FWA) laws;**
- **Assist you in the prevention, detection and resolution of accidental and intentional non-compliance with those laws;**
- **Ensure you understand your responsibilities for preventing, detecting, and reporting violations, and of HNS' disciplinary actions for non-compliance.**

Who Must Complete this Compliance Training?

- **HNS contracted heath care professionals**.
- **All employees** of contracted health care professionals.
- **Vendors/contracted individuals or entities.** If your organization has contracted with individuals or entities to provide health and/or administrative services on behalf of federal health plan members, you must also provide this training to those subcontractors. (***An example of an entity to which you must provide this training is a billing company you contract with for billing/collection services.)***

Written Standards & Policies

Pursuant to compliance guidance issued by the Office of the Inspector General (OIG), HNS has developed written compliance policies (**HNS Compliance Policies for Contracted Health Care Professionals**) which establish HNS' expectations for contracted health care professionals. Those policies are included in this training module.

Additionally, HNS maintains written business policies and procedures (P&Ps) for contracted health care professionals developed to improve quality of care, treatment outcomes, and to provide guidance for routine and required operational processes. These policies are posted on the HNS website.

HNS reserves the right to periodically review and revise its policies and will provide timely notification to contracted health care professionals of any material changes.

HNS' P&Ps will comply with all applicable federal and state laws, regulations, and requirements related to Medicare, Medicaid, and private health care programs.

Compliance Responsibilities

Based on recommendations by the OIG for organizations like HNS, which contract with health care professionals, HNS has enumerated those compliance functions that are shared responsibilities of HNS and our contracted health care professionals, those which are the sole responsibility of HNS, and those which are the sole responsibility of contracted health care professionals.

Shared Responsibilities of HNS and HNS Contracted Health Care Professionals

The following
are responsibilities of
both
HNS and contracted health care professionals.

Shared Responsibilities of HNS and HNS Contracted Health Care Professionals

Both HNS and our contracted health care professionals are responsible for:

- Complying with all applicable federal and state laws and regulations;
- Adhering to the HNS Standards of Conduct, Code of Ethics, and generally recognized professional ethical standards;
- Cooperating with all compliance investigations;
- **Developing and maintaining a written compliance plan that seeks to detect, prevent, and correct instances of non-compliance; and which specifically includes policies and procedures for compliance to both HIPAA regulations and fraud, waste and abuse laws.**
- Maintaining all records relating to compliance programs for a period of 10 years;

Shared Responsibilities of HNS and HNS Contracted Health Care Professionals

Both HNS and our contracted health care professionals are responsible for:

- Investigating and correcting instances of non-compliance;
- Reporting all suspected or actual instances of non-compliance and immediately escalating any incidents of suspected fraud, waste and abuse;
- Ensuring employees and contractors are eligible for participation in federal health care plans (both at initial hire and monthly thereafter) by querying the OIG's List of Excluded Individuals & Entities (LEIE);
- Retaining documentation which substantiates that the organization conducted the initial and monthly reviews of the List of Excluded Individuals & Entities. This information must be available upon request by HNS, contracted health care plans, and CMS. These records must be maintained for 10 years;

Shared Responsibilities of HNS and HNS Contracted Health Care Professionals

Both HNS and our contracted health care professionals are responsible for:

- Removing any employee (or contractor) who has *pending* criminal charges relating to health care, or *proposed exclusion* from participation in any federally or state funded health care program from direct responsibility or involvement in any federally or state funded health care programs;

- Ensuring we do not act in a manner that prohibits competition. We shall not communicate formally or informally with competitors to fix or control prices, allocate markets, boycott customers or suppliers, or limit the sale of our products/services;

Shared Responsibilities of HNS and HNS Contracted Health Care Professionals

Both HNS and our contracted health care professionals are responsible for:

- Ensuring that we develop, implement, enforce, and audit policies and procedures to identify, investigate and report instances of fraud, waste or abuse.
- Ensuring that we develop, implement, enforce, and audit policies and procedures to ensure the privacy and security of protected health information (PHI) and the confidentiality of personal and other information protected by statute;
- Ensuring appropriate safeguards are in place to maintain the integrity of our information and billing systems and to prevent the unauthorized access of computer systems, including but not limited to, anti-virus protection and appropriate internal safeguards; and
- Maintaining back-up systems that ensure our ability to retrieve data in the event of an emergency or disaster.

Responsibilities of HNS

The following

Compliance Policies

represent the responsibilities of HNS.

Responsibilities of HNS

Integrity of HNS Employees
Prior to, or within the first 30 days of employment with HNS, HNS shall conduct reasonable and prudent background investigations of each employee which shall include criminal background checks.

HNS shall prohibit employment of individuals who have been recently convicted of a criminal offense related to health care or who are listed as debarred, excluded, or otherwise ineligible for participation in federal health care programs.

HNS shall prohibit contracting with individuals or entities who are ineligible for participation in federal health care programs.

Responsibilities of HNS

Education and Training
HNS shall be responsible for making compliance training available to our employees, officers, directors (herein after referred to as HNS personnel), and to all contracted health care professionals, both for their own training and for training their staff members.

Open Communication
HNS shall be responsible for ensuring open and effective lines of communication between HNS and HNS personnel, and between HNS and our contracted health care professionals.

HNS shall maintain toll-free telephone and facsimile lines to promote open and frequent communication. HNS shall communicate those numbers to HNS personnel, to members, and to HNS contracted health care professionals by posting those numbers on the HNS website.

Responsibilities of HNS

Quality of Health Care Data

HNS shall be responsible for ensuring we do not alter or modify the health care data on claims received from contracted health care professionals.

HNS shall be responsible for ensuring the accuracy of claims data manually input into HNS computer systems by HNS personnel.

Except as indicated here, HNS shall not be responsible for the accuracy, validity, or quality of claims data submitted to HNS by contracted health care professionals.

Auditing / Monitoring

HNS shall conduct periodic monitoring and auditing for compliance to laws and regulations.

Responsibilities of HNS

Suspicious Claims

HNS shall prevent the submission of all claims when HNS suspects fraud or deceit until such time as HNS can determine if a violation has occurred. HNS shall notify the contracted health care professional, in writing, of this determination within 30 days of the date of the determination. The notification shall include all claim specific information and the rationale for such a determination.

Duplicate Billing

HNS shall implement internal controls designed to prevent the submission of duplicate claims. (*HNSConnect*® shall include an edit designed to identify duplicate claims (as defined by HNS parameters) and prevent the submission of those claims.)

Responsibilities of HNS

Notification

HNS shall be responsible for the timely notification to HNS personnel and contracted health care professionals of suspected violations of applicable laws, HNS' policies, and the policies of contracted health care plans, as well as the results of the investigation of such violations.

Sanctions for Non-Compliance

HNS shall be responsible for developing and enforcing disciplinary guidelines and sanctions for non-compliance and shall ensure HNS' Sanction Policies are well publicized by posting these policies in a prominent location at HNS offices and on the Compliance section of the HNS website.

Compliance Training Responsibilities

Compliance Training Requirements for Contracted Health Care Professionals

- **Initial Training:** contracted health care professionals shall complete this training module within 15 days of the effective date of their participation in the HNS Network.

- **Annual Compliance:** contracted health care professionals shall complete this training annually, by the end of July of each year (unless another date is specified by HNS).

- **Compliance Training Certification:** all contracted health care professionals must complete the Compliance Training Certification form which is included at the end of this training module and *a signed and dated copy of this certificate must be provided to HNS by the due dates indicated above*. The certificate may be emailed or faxed to HNS.

HNS Fax Number: (877) 329-2620

Compliance Training Responsibilities

Employee Training Required
Contracted health care professionals shall ensure all their employees complete this training module **annually**. While copies of certificates of completion of the training must be maintained by the contracted health care professional, *those are not required to be submitted to HNS.*

Vendor Training Required
Contracted health care professionals shall ensure that applicable vendors/contractors receive this training **annually**. While copies of certificates of completion of the training must be maintained by the contracted health care professional, *those are not required to be submitted to HNS*.

Retention of Training Records

Retention of Compliance Records
Contracted health care professionals shall maintain ALL records associated with their own compliance training; the training of their employees and contractors and vendors (as applicable) for **10 years**. At a minimum, records which must be maintained include:

- The name of the individual or entity that completed the training;
- The date of the training;
- The training material used (i.e. a copy of this training module); and
- Copies of the HNS Compliance Training Certification.

These records shall be available if requested by HNS, contracted health care plans, and/or CMS.

Failure to Comply with Training Requirements

Failure to comply with all **HNS Compliance Training requirements**, as outlined herein, may result in the temporary suspension of contracted health care professional's access to *HNSConnect®,* or to the submission of claims to HNS via *Office Ally™,* and/or termination from the network.

Ethical Standards

Ethical and Professional Standards

Each of us must comply with all
federal and state laws and regulations.
Our first and most fundamental obligation is to
obey both the letter and spirit of the law.

Contracted health care professionals
shall adhere to generally recognized standards of medical
and professional ethics, the ethical and professional standards set
forth by their respective licensing board,
and the **HNS Code and Standards of Conduct**.

HNS' Code of Conduct

The HNS Code of Conduct is a guide that helps us carry out our day-to-day professional responsibilities in accordance with the highest possible standards of ethical behavior and in compliance with laws that regulate our business.

Everyone in the HNS Network shall:

- Conduct themselves in a manner consistent with generally accepted ethical principles and the HNS Code and Standards of Conduct;
- Treat each other and all those we serve with kindness, respect, and the highest degree of professionalism;
- Conduct themselves in accordance with all state and federal laws and regulations, HNS policies, and the policies of contracted health care plans; and
- Perform all responsibilities professionally, diligently, in good faith, and to the best of their ability.

Standards of Conduct

Each of us is expected to act with the highest degree of integrity and professionalism.

All contracted health care professionals shall at all times conduct business with fairness, honesty, integrity, professionalism, and respect for the laws applicable to the health care industry.

Even in cases where interpretation
of the law of this Standard could be ambiguous, permissive,
or lenient, HNS expects its contracted health care professionals to
always do the right thing, in the right way,
and choose the course of honesty and integrity.

Legal Standards (Relevant Laws)

While the scope of this Compliance Training may be expanded in the future to cover additional areas of regulatory compliance applicable to the health care industry, this section of the training focuses on the following laws:

- Fraud, Waste and Abuse **(FWA)** Laws
- Personal Information Privacy and Security Laws **(HIPAA)**

Fraud, Waste and Abuse (FWA)

FWA is Everyone's Problem

Health care fraud and abuse is a national problem that, either directly or indirectly, affects all of us.

National estimates project that billions of dollars are lost to health care fraud and abuse on an annual basis.

These losses lead to increased health care costs and potential increased costs for health care coverage.

FWA laws apply to all HNS contracted health care professionals.

Written FWA Policies & Procedures

Each physician's compliance plan must specifically include *written policies and procedures* intended to ensure compliance to fraud, waste and abuse laws.

What is Fraud, Waste & Abuse?

Fraud is knowingly and willfully executing, or attempting to execute, a scheme to:

- Defraud any health care program; and/or
- 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, a health care program.

Waste is overutilization of services or other practices that directly or indirectly result in unnecessary costs to our health care system. Waste is generally not considered to be caused by criminally negligent actions, but rather by misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to America's health care system. Abuse involves payment for items/services when there is not a legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

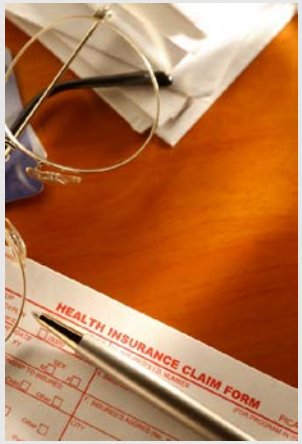
Differences Between Fraud, Waste & Abuse

The real difference between fraud and waste and abuse is the person's intent.

Fraud is an *intentional* deception or misrepresentation that someone makes, knowing it is false, that could result in unauthorized benefit/payment. It is important to note that attempt itself is fraud, regardless of whether it is successful.

Waste and abuse involves actions that are inconsistent with accepted, sound medical, business, or fiscal practices. Waste and abuse result in unnecessary costs to CMS and America's health care delivery system through improper payments.

Examples of FWA



*Examples of **fraud**:*

- Intentionally billing for services not furnished
- Upcoding
- Altering medical records to justify payments

*Examples of **waste and/or abuse**:*

- Billing for services that are not medically necessary
- Performing unnecessary tests on a beneficiary to establish medical necessity
- When the diagnosis for the member is not supported in the medical record
- Retaining reimbursement for services not owed to the health care professional

Quality of Health Care Data

Quality of Health Care Data
Contracted health care professionals shall ensure the validity, reliability, accuracy, and quality of health care data submitted to HNS and to any federal or private health care plan.

The validity, reliability, accuracy, and quality of health care data submitted to HNS by contracted health care professionals shall be the ***sole responsibility*** of the contracted health care professional who provided the services (and/or under whose supervision the services were provided), and whose name is on the claim form as the rendering provider.

HNS' Response to Suspected FWA

If HNS suspects fraud, waste or abuse
by a contracted health care professional,
HNS may refrain from the submission to payors,
any claims submitted by the physician,
until an investigation has been completed
and/or until a final determination has been made.

FWA Regulatory Agencies

The primary regulatory agencies for FWA laws are:

- **The Department of Health & Human Services (DHHS) Office of the Inspector General (OIG)**

- **Centers for Medicare and Medicaid Services (CMS)**
  CMS is a federal entity within the U.S. Department of Health and Human Services. CMS is responsible for oversight of the Medicare and Medicaid programs.

Relevant FWA Laws

Some of the most important federal Fraud, Waste and Abuse laws applicable to our contracted health care professionals are:

- The Federal False Claims Act (FCA)
- The Anti-Kickback Statute (AKS)
- The Physician Self-Referral Law (Stark Law)
- Civil Monetary Penalties Law
- The Exclusion Authorities

Federal False Claims Act (FCA)

The Federal False Claims Act, sometimes referred to as the FCA or Lincoln Law, is a law that creates liability for the intentional submission of false claims to the government. This law is a powerful tool used by the government to combat fraud.

Federal False Claims Act (FCA)

Under the False Claims Act, anyone who “knowingly” submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties for each false claim submitted.

The law was revised in 1986 to expand the definition of “knowingly” to include a person who:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in the claim;
- Acts in reckless disregard of the truth or falsity of the information in a claim.

Federal False Claims Act (FCA)

False Claims suits can be brought against individuals and entities.

The False Claims Act does not require proof of a specific intent to defraud the Government. Providers can be prosecuted for a wide variety of conduct that leads to the submission of a false claim. Some examples include:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- Using false records or statements to avoid paying the Government;
- Falsifying time records used to bill Medicaid; or
- Otherwise causing a false claim to be submitted.

Qui Tam (Whistleblower Provision)

An important provision of the **False Claims Act** is known as “qui tam,” which allows any person or entity to bring actions to enforce the False Claims Act. Under qui tam, any person with evidence of fraud against federal programs or contracts may file a qui tam lawsuit on behalf of the U.S. Government. The government has the right to intervene and join the action. Those who file qui tam lawsuits are informally known as “**whistleblowers**.”

As compensation for the risk and effort of filing a qui tam case, the whistleblower may be awarded a portion of the funds recovered.

Any person who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of filing a qui tam case is entitled to seek double the amount of back-pay, reinstatement, and other damages and fees.

Violations / Penalties of the False Claims Act

Violators of the False Claims Act are required to pay the federal government
three (3) times the amount of damages
sustained by the government and civil penalties
between $5500 and $$10,781 - $21,562
for each false or fraudulent claim.

Anti-Kickback Statute (AKS)

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash.

In federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks (those who offer or pay remuneration), as well as the recipients of kickbacks (those who solicit or receive remuneration).

Each party's intent is a key element of their liability under the AKS.

Anti-Kickback Statute (AKS)

This statute imposes penalties on any person that knowingly and willfully solicits, receives, offers, or pays any remuneration (including any kick-back, bribe, or rebate) for referrals for services that are paid in whole or in part by a federal health care program, which includes Medicare and Medicaid.

In other words, it is a crime
for individuals or entities to knowingly or willfully
offer, pay, solicit, or receive something of value
in exchange for rewarding referrals of business
under federal health care programs.

Anti-Kickback Statute (AKS)

The primary function of the Anti-Kickback Statute is to ensure that financial motives do not undermine the integrity of the medical judgment that must be maintained by health care professionals.

This statute promotes referrals based on medical need rather than referrals based on financial or other types of incentives.

Penalties of AKS

The Federal Anti-Kickback Statute is a **criminal statute** and the penalties for violations can be severe.

Penalties can include up to **$25,000** per violation, felony conviction punishable by imprisonment of up to **5 years**, **or BOTH**, as well as possible exclusion from participation in federal health care programs.

Physician Self-Referral Law (Stark Law)

Commonly called the “Stark Law” after U.S. Congressman Pete Stark, who initially sponsored the bill, this law addresses the practice of a physician referring a patient to a medical facility in which the physician has a financial interest, be it ownership, investment, or a structured compensation arrangement.

This law prohibits a physician from referring Medicare or Medicaid patients for certain **designated health services** to an entity in which the physician, or an immediate family member, has a financial interest.

Similar to the Anti-Kickback Statute, the primary function of this statute is to ensure that financial motives do not undermine the integrity of the medical judgment of health care providers.

“Designated Health Services” under Stark

- Designated health services include:

  - ✓ Radiology & imaging services;
  - ✓ Physical & occupational therapies;
  - ✓ DME and supplies (example: TENS units);
  - ✓ Clinical laboratory services;
  - ✓ Prosthetics, orthotics, & prosthetic devices & supplies;
  - ✓ Outpatient speech/language pathology services;
  - ✓ Radiation therapy services & supplies;
  - ✓ Parenteral and enteral nutrients, equipment & supplies;
  - ✓ Home health services;
  - ✓ Outpatient prescription drugs; and
  - ✓ Inpatient & outpatient hospital services.

Penalties – Stark Law

Penalties for violating the Stark Law include:

- Denial of payment from Medicare/Medicaid for those services that violated the Stark Law;
- Exclusion from the Medicare and Medicaid programs;
- Any payment received from a prohibited referral must be refunded;
- Up to $**15,000 fine** for EACH service provided that a person “knows or should know” was provided in violation of this statute; and
- Up to $**100,000 fine** for entering into an arrangement or scheme that violates this law.

Proof of specific intent to violate the law is not required.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to:

(1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way;

(2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient;

(3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services;

Civil Monetary Penalties Law

(4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program;

(5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or

(6) using a payment intended for a federal health care program beneficiary for another use.

Exclusions Law

The Health and Human Services, Office of Inspector General (HHS OIG) and Office of Personnel Management, Office of Inspector General (OPM OIG) have authority to exclude from participation in federal health care programs individuals and entities sanctioned for certain fraud, waste and abuse violations.

Federal agencies have general authority to debar or suspend individuals from work on government grants or contracts, or to provide services under federal health care programs like Medicare and Medicaid.

Exclusions Law

Once an individual or entity has been excluded or debarred from a federal or state health care program, no federal money may be used to pay for goods or services that the individual or entity provide.

In addition, any entity that knowingly employs or contracts with an excluded or debarred individual or entity for the provision of goods or services *may be subjected to civil monetary penalties*.

Exclusions Law

To ensure employees and contractors are eligible for participation in federal health care plans, contracted health care professionals must, **both at initial hire and monthly thereafter,** query the OIG's List of Excluded Individuals & Entities (LEIE) for all employees/associates and applicable vendors/contractors.

web address: http://exclusions.oig.hhs.gov

Contracted health care professionals must retain documentation which substantiates that the initial and monthly query of the LEIE was conducted. This information must be available upon request by HNS, contracted health care plans, and CMS. These records must be maintained for 10 years.

Consequences of Committing Fraud, Waste or Abuse

The following are potential consequences for committing Fraud, Waste or Abuse. The actual consequence depends on the violation, but may include:

- Civil Money Penalties
- Criminal Conviction/Fines
- Imprisonment
- Loss of Physician License
- Exclusion from federal health care programs
- Termination of participation in the HNS network

Best Practices to Assure Compliance to FWA Laws…

- Be committed to ensuring compliance with FWA laws.
- Develop and document policies and procedures to ensure compliance and provide annual FWA training to employees.
- Always be on the lookout for suspicious activity and report it.
- Always verify insurance information provided by members with the applicable health care plan.
- Ensure the information in the health care record is accurate.
- Ensure the information reported on claims is accurate and consistent with the information in the health care record.

Best Practices to Assure Compliance to FWA Laws…

- **At least quarterly, conduct auditing and monitoring of health care records and claims data to assure accuracy of information on the claims.** If you determine an inadvertent error, promptly file a corrected claim to correct the error.
- If you receive payment for services you did not provide or *to which you are not entitled*, immediately notify HNS (or the entity that issued the payment) to arrange to refund those monies.
- Stay up-to-date with laws, regulations, and policies, including all HNS Policies and the medical policies of contracted payors.

HIPAA

HIPAA

The **Health Insurance Portability and Accountability Act (HIPAA)** is a federal law passed in 1996 due to the rapid growth of health information systems and the need to ***safeguard individuals' health information***.

HIPAA contains provisions and rules to protect privacy and help control fraud, waste, and abuse within the health care system.

The primary regulatory agency for HIPAA laws is the Department of Health & Human Services, Office of Civil Rights (OCR).

Written HIPAA Policies & Procedures

Each physician's compliance plan

must specifically include

written policies and procedures

intended to ensure compliance to HIPAA laws and regulations.

HIPAA

HIPAA is comprised of many components. The focus of this HIPAA training is:

- The Federal Beneficiary Inducement Statute
- The HIPAA Privacy Rule
- The HIPAA Security Rules

Who Must Comply with HIPAA?

HIPAA applies to Covered Entities and Business Associates.

Covered Entities (CE) are individuals or entities who **transmit any health information in electronic form in connection with a transaction.**

Business Associates (BA) are those to whom the Covered Entity discloses protected health information (PHI) to carry out, assist with performance of, or perform on the behalf of, a function or activity for the Covered Entity.

Covered Entities

CEs include health plans, health care professionals, health care clearinghouses, and employer sponsored health plans.

Health Plans – Individual and group plans that provide or pay the cost of medical care are **Covered Entities**.

Health Care Providers – Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a **Covered Entity**. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which the Department of Health and Human Services (HHS) has established standards.

Note: Using electronic technology, such as email, does not mean a health care provider is a Covered Entity; the transmission must be in connection with a standard transaction.

Covered Entities

Health Care Clearinghouses

Health care clearinghouses are entities that process nonstandard information they receive from another entity into standard (i.e., standard format or data content), or vice versa and are **Covered Entities** under HIPAA.

(HNS falls under the category of a health care clearinghouse.)

Business Associates

In general, a Business Associate (BA) is a person or organization, other than a member of a Covered Entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a Covered Entity that involve the use or disclosure of individually identifiable health information.

Business Associate functions or activities on behalf of a Covered Entity include claims processing, data analysis, quality and utilization review, and billing. However, persons or organizations are not considered Business Associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all.

A Covered Entity can be the Business Associate of another Covered Entity.

(HNS is a Covered Entity as defined by HIPAA, but acts as a *Business Associate* of each contracted health care professional.)

Business Associate Agreements (BAA)

When a Covered Entity uses a contractor or other non-workforce member to perform *“Business Associate"* services or activities, the Privacy Rule requires that the Covered Entity include certain protections for the information in a *Business Associate Agreement (BAA)*. In the Business Associate Agreement, a Covered Entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its Business Associates. Moreover, a Covered Entity may not contractually authorize its Business Associate to make any use or disclosure of protected health information that would violate the HIPAA Regulations.

(HNS maintains BAAs with each contracted health care professional.)

Protected Health Information

Protected Health Information (PHI) is individually identifiable health information that is transmitted or maintained **in any form or medium** (e.g., electronic, paper, or oral).

To be considered PHI, the information must have <u>two (2) components</u>:

- **Medical Information** – Information about an individual's past, present, or future physical or mental health care; and
- **Personally Identifiable Information** – Data elements that can identify or reasonably lead to the identification of an individual.

Examples of Personally Identifiable Information

Personally identifiable Information includes <u>any</u> unique identifying number, characteristic or code.

Examples include:

- Names
- Addresses
- Dates, including birth date, date of service, date of death, etc.
- Telephone or fax number
- E-mail address
- Subscriber ID number

Examples of Personally Identifiable Information

- Social Security numbers
- NPI numbers
- URL/IP addresses
- Full-face photos and comparable images
- License numbers, account numbers, medical record number
- Vehicle identifier and serial numbers (license plates)
- Device identifiers & serial numbers

HIPAA Regulations

Federal Beneficiary Inducement Statute

This law is part of **HIPAA,** and makes it **illegal** to offer a remuneration that a person knows, or should know, is likely to influence a patient to select a particular provider or supplier.

The statute defines “remuneration” to include, without limitation,

- **waivers of co-payments and deductible amounts** (or any part thereof) and
- **transfers of items or services for free or for other than fair market value.**

Penalties – Federal Beneficiary Inducement Statute

Violations of the Federal Beneficiary Inducement Statute may result in civil money penalties (CMPs) of up to

$10,000 for <u>each</u> wrongful act.

HIPAA Regulations – Privacy Rule

The Privacy Rule is a core component of HIPAA. The Privacy Rule is a set of standards for the **protection of certain health information**.

These standards address the **use and disclosure** of individually protected heath information.

The standards also **grant specific rights to members**.

HIPAA Privacy Rule

The Privacy Rule protects
ALL "individually identifiable health information",
also called Protected Health Information *(PHI)* held or transmitted by a Covered Entity or its Business Associate
in any form or media, whether electronic, paper, or oral.

HIPAA Regulations – HIPAA Security Rules

The HIPAA Security Regulations outline specific protections and safeguards for ***electronic*** Protected Health Information.

HIPAA Security Rules

While the HIPAA Privacy Rule protects the privacy of all PHI, the **Security Rule** protects a subset of information covered by the Privacy Rule.

The subset of information protected by the Security Rule is all ***individually identifiable health information a Covered Entity creates, receives, maintains, or transmits in electronic form***.

The Security Rule calls this information “electronic protected health information” (**e-PHI**).

The Security Rule does NOT apply to PHI transmitted orally or in writing.

Examples of PHI Subject to the Security Rules

- Emails that include PHI.
- Claims that are received or transmitted electronically.
- Remittance information (EOB) that is received or transmitted electronically.

HIPAA Omnibus Rule

The Omnibus Rule is a set of regulations modifying HIPAA's Privacy, Security, and Enforcement Rules to implement various provisions of the HITECH Act.

Highlights of the Omnibus Rule include:

- Makes Covered Entities and their Business Associates directly liable for compliance with certain requirements;
- Strengthens the limitations on the use and disclosure of PHI; and
- Expands an individual's rights to receive and restrict his/her electronic health information for which the member has paid out-of-pocket in full.

HITECH

The Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted in 2009, as part of the American Recovery and Reinvestment Act (ARRA) **to encourage the adoption and "meaningful use" of electronic health records** (EHR), as the use of EHR has been shown to improve quality, safety, and coordination of health care.

PHI - Use & Disclosure

The HIPAA Privacy Rule defines and limits the circumstances in which an individual's PHI may be used and disclosed.

Use – to use means to share, utilize, examine, or analyze PHI *within your organization*.

Disclose – to disclose means to release, transfer, or share PHI to an individual or entity *outside of your organization.*

Covered Entities shall not use or disclose an individual's PHI *except as permitted by law*.

Use and Disclosure- Minimum Necessary

The Privacy Rule includes a **Minimum Necessary Rule**. This rule restricts the use and disclosure of PHI to ONLY the amount necessary to perform a specific task. To comply with this rule:

- Use the least amount of PHI required to complete the task;
- Look at PHI only if the task requires it;
- Talk to others about PHI only if it is necessary to perform the task; and
- Give PHI to others only when it is necessary for them to perform their tasks.

PHI - Use & Disclosure

HIPAA allows the use and disclosure
of PHI (without the member's consent)
if it relates to
Treatment, Payment, or **Operations**,
which is referred to as **TPO**.

PHI - Use & Disclosure

Besides TPO, there are very specific situations when a Covered Entity can Disclose PHI *without a member's consent.* These allowed disclosures can include, but are not limited to:

- If required by law or law enforcement;
- For public health reasons;
- To report abuse; and
- To avert a serious threat.

Required Disclosures of PHI

You are required to disclose PHI:

- To an individual member seeking to access their PHI in your possession;
- To the Secretary of Health and Human Services (HHS) to investigate or determine compliance with regulations; and
- As otherwise required by law.

Permitted Use & Disclosures of PHI

You are **permitted** to use/disclose PHI:

- To carry out health care operations;
- To the individual patient, or authorized representative with a valid authorization from the patient; and
- To those with whom you do business, such as HNS, health care or managed care plans with which you contract, certain vendors (ex: your billing company), and BAs, **provided you have first obtained satisfactory assurances that the information will be adequately safeguarded.**

Breach

A “**breach**”
is an unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA.

The **Breach Notification Rule**
requires HIPAA Covered Entities and their Business Associates to provide notification following a breach of unsecured PHI.

Breach Notification Rule

The Breach Notification Rule has specific requirements regarding who must be notified in the event of a breach:

- **Individuals** who are affected by a breach must be notified within 60 days from the time of discovery;
- The Covered Entity must maintain an annual log of all breaches. Logs of breaches involving **less than 500 individuals** must be submitted to the Secretary of the Department of Health and Human Services annually, no more than 60 days after the end of the calendar year;
- The media must be notified of any breaches that involve 500 or more individuals no later than 60 days from discovery; and
- If a breach involves 500 or more individuals, the Secretary of the **U.S. Department of Health and Human Services** (HHS) must be notified without unreasonable delay and *in no case later than 60 days following the discovery of the breach.*

Breach Notification Rule

Per the Rule, **it is NOT a breach when**:

- The information is accessed unintentionally by a workforce member or someone working under the authority of a CE or BA, if it was done in good faith and within the scope of authority, etc.;
- It is an inadvertent disclosure by a person authorized to access PHI to another person authorized to access PHI at the SAME Covered Entity, BA, or organized health care arrangement in which the Covered Entity participates; or
- Where the Covered Entity or BA has a good faith belief that the unauthorized person would not reasonably have been able to retain the PHI.

Breach Notification Rule

Per the Rule, **it is presumed to be a breach unless** the Covered Entity or BA demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the PHI involved, including identifiers;
- The unauthorized person who used the PHI or to whom it was disclosed;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk was mitigated.

NC & SC
Breach Reporting Requirements

In addition to reporting to federal agencies and media:

North Carolina law requires that in the event of a breach of *personal* information we:

- Immediately notify the individual; and
- Report the breach to the NC Consumer Protection Division of the Attorney General's Office.
- Below is the web address which can be used to report:
  - http://www.ncdoj.gov/Protect-Yourself/2-4-3-Protect-Your-Identity/Protect-Your-Business/Report-a-Security-Breach.aspx

South Carolina law requires that in the event of a breach of *personal* information we:

- Immediately notify the individual;
- If more than 1000 people at one time, report the breach to the SC Office of Consumer Affairs and all national consumer reporting agencies.
- Below is information on how to report:
  - Phone: 1-800-922-1594
  - Email: scdca@scconsumer.gov
  - SC Office of Consumer Affairs
    PO Box 5757
    Columbia SC 29250-5246

HIPAA
Penalties / Violations

The improper acquisition, access, use, or disclosure of PHI is a violation of HIPAA. HIPAA penalties can be severe.

Civil monetary penalties for non-compliance depend on the nature of the violation and can range from $**100-$50,000 per violation**, with a maximum penalty of **$1.5 million per year** for violations of an identical provision.

Criminal Penalties can range from **$50,000-$250,000** and between **1 and 10 years imprisonment**.

Patient Rights Under HIPAA

Under HIPAA, each individual has rights regarding their PHI. These rights include:

- The right to receive a copy of the health care professional's "Notice of Privacy Practices," which details how individually identifiable health information may be used or disclosed by the organization;
- The right to review or obtain a copy of medical records about that member or, as applicable, the member's minor children;
- The right to request restrictions on the use or disclosure of the member's medical records;

Patient Rights Under HIPAA

- The right to receive individually identifiable health information at an alternate address or through alternate delivery means, such as by fax or courier;
- The right to request amendments to medical records, with certain limitations;
- The right to an accounting of certain disclosures of individually identifiable health information; and
- The right to file a privacy complaint directly with the contracted health care professional, HNS, or with the federal government.

Best Practices to Assure Compliance to HIPAA Laws…

Be committed to complying with HIPAA rules.

Develop and document privacy policies and procedures and provide annual HIPAA training to employees.

Report and track improper disclosures of PHI.

Conduct, at a minimum, an annual risk assessment and whenever there is a change in business operations that would necessitate a new risk assessment.

Best Practices to Assure Compliance to HIPAA Laws…

- Speak quietly and *only to those necessary* when discussing PHI with ANYONE.
- Never discuss member information or conditions in common areas.
- Verify that you have the correct email address before emailing PHI.
- Send all e-mails that contain PHI via a secure email system.
- Verify that you have the correct fax number before faxing PHI.
- Always include an appropriate disclaimer when faxing or emailing PHI.
- Do not leave documents containing PHI in any common areas, other than as required to fulfill duties and responsibilities.
- Disclose only the minimum amount of PHI necessary to accomplish the task.
- Ensure Business Associate Agreements are in place with applicable individuals and/or organizations.

Best Practices to Assure Compliance to HIPAA Laws…

- Never give out confidential information unless you are certain the recipient has a right to the information.
- Never share your computer password with anyone.
- Change computer passwords every 45 days.
- Never open links included in emails unless you are confident the email is from a trusted source.
- Never open attachments to emails unless you know the email is from a trusted source.
- Never access PHI using a public Wi-Fi system.
- Ensure the proper disposal of PHI.
- Ensure your computer will lock automatically after 15 minutes of inactivity.
- Ensure all computers and servers have up-to-date anti-virus and malware protection.

Best Practices to Assure Compliance to HIPAA Laws…

- Develop and enforce social media policies.
- Keep personal social media accounts separate from practice accounts.
- Never post or share photographs, or any form of PHI, on social media without written consent from the patient or his/her legal guardian.
- Understand that even if a patient posts every last detail about his or her health and treatments, no health care professional or staff should repost or retweet this information.
- Never comment on a patient's Facebook page about their health condition or treatment.

Compliance Policies for Contracted Health Care Professionals

To promote awareness among contracted health care professionals of our legal environment, and to promote compliance with state and federal laws relevant to the health care industry, and to prevent accidental and intentional non-compliance to those laws, HNS has developed specific **Compliance Policies for Contracted Health Care Professionals** which outline their compliance responsibilities.

These policies are consistent with guidance issued by the Office of Inspector General (OIG) industry standards and federal and state laws.

HNS reserves the right to review and modify its Compliance Policies at any time and will provide timely notification to contracted health care professionals of any material changes.

Compliance Policies for Contracted Health Care Professionals

The following slides include the HNS Compliance Policies for Contracted Health Care Professionals. (These are also posted on the HNS website.)

HNS recommends contracted health care professionals print/save these policies and review them frequently.

These policies establish
HNS' performance expectations
for all contracted health care professionals.

Failure to Comply

Failure by contracted health care professionals to comply with all HNS Compliance Policies may result in termination of participation from the HNS network and reporting of the non-compliance to applicable authoritative bodies.

HNS Compliance Policies for Contracted Health Care Professionals

1. Compliance to Laws, Regulations and Policies

Contracted health care professionals shall comply with all applicable federal and state laws and regulations, HNS Compliance and Business Policies, and the policies of HNS contracted health care plans. (HNS Business Policies should not be followed if compliance to those policies would adversely affect the health or safety of a patient.)

2. Ethical and Professional Standards

Contracted health care professionals shall adhere to generally recognized standards of medical and professional ethics and the ethical and professional standards set forth by their respective licensing board, the HNS Code of Ethics and HNS' Standards of Conduct.

HNS Compliance Policies for Contracted Health Care Professionals

3. Written Compliance Plan

Contracted health care professionals shall maintain a written compliance plan, which shall include written policies and procedures intended to promote compliance to applicable laws and regulations, HNS policies and the policies of contracted health care plans.

4. PHI and PII

(Protected Health Information and Personally Identifiable Information)

A. Contracted health care professionals shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the Privacy Rule, Security Rule and Health Information Technology for Economic and Clinical Health Act (HITECH), regarding the use, disclosure and safeguards for protected health information (PHI), including electronic PHI, and ensure controls are in place to provide reasonable assurance that access to PHI and PII is limited to properly authorized individuals.

HNS Compliance Policies for Contracted Health Care Professionals

B. Contracted health care professionals must establish and implement operational, technical, administrative and physical safeguards that are consistent with applicable laws to ensure:

- The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed.
- Personally identifiable information is only used by or disclosed to those authorized to receive or view it.
- Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information.
- Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law.
- Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

HNS Compliance Policies for Contracted Health Care Professionals

C. Contracted health care professionals shall comply with the following:

- *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format.

- *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied.

- *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information.

HNS Compliance Policies for Contracted Health Care Professionals

- *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information.

- *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately.

- *Data quality and integrity.* Contracted health care professionals shall take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner.

HNS Compliance Policies for Contracted Health Care Professionals

- *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.

- *Accountability.* Adherence to these policies should be monitored through appropriate auditing/monitoring activities and processes established to ensure non-compliance is identified and mitigated.

- *Integrity of Information Billing Systems.* Contracted health care professionals shall ensure appropriate safeguards are in place for billing/information systems in order to maintain the integrity of all patient health care data and which prevent the unauthorized access of computer systems, including but not limited to, anti-virus protection and appropriate internal safeguards.

HNS Compliance Policies for Contracted Health Care Professionals

D. Contracted health care professionals shall maintain appropriate back-up systems that ensure their ability to retrieve data in the event of an emergency or disaster.

5. False Claims Act

The False Claims Act is a federal law designed to prevent and detect fraud, waste and abuse in federal health care programs, including Medicare and Medicaid, and imposes liability on persons and companies who defraud governmental programs. Under the False Claims Act, anyone who “knowingly” submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties for each false claim submitted.

The validity, reliability, accuracy and quality of health care data submitted to HNS by contracted health care professionals shall be the ***sole responsibility*** of the contracted health care professional who provided the services (and/or under whose supervision the services were provided), and whose name is on the claim form as the rendering provider.

HNS Compliance Policies for Contracted Health Care Professionals

If HNS suspects fraud, waste or abuse by a contracted health care professional, in addition to other actions, HNS may refrain from the submission of any claims submitted by the physician until an investigation has been completed and/or until a final determination has been made.

A. Contracted health care professionals shall be solely responsible for ensuring the validity, reliability, accuracy and quality of health care data submitted to HNS and to any federal or private health care plan.

B. Contracted health care professionals shall ensure that claims are only submitted for payment when documentation in the health care record supports the services or items on the claims, and only when such documentation is legible, maintained, appropriately organized, and is available for audit and review.

C. Contracted health care professionals shall not intentionally present, or cause to be presented, a false or fraudulent claim for payment or approval.

HNS Compliance Policies for Contracted Health Care Professionals

D. Contracted health care professionals shall not knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.

E. Contracted health care professionals shall conduct periodic auditing and monitoring of health care records and claims data to ensure the accuracy of the information provided on claims and to assist in the detection of non-compliance to FWA laws, and to these policies.

6. Anti-Kickback Statute (AKS)

The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash. In federal health care programs, paying for referrals is a crime.

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals shall not knowingly and willfully:

A. Offer, pay, solicit, or receive remuneration (i.e., anything of value, in cash or in kind) in order to induce or reward the referral of business reimbursable by a federal or state health care program.

B. Solicit or receive any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program.

C. Solicit or receive any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program.

HNS Compliance Policies for Contracted Health Care Professionals

D. Offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to refer an individual to a person for the furnishing or arranging of any item or service for which payment may be made in whole or in part under a federal health care program.

E. Offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to purchase, lease, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program.

Remuneration does not include legally permitted practices such as group purchasing agreements and price reduction agreements with health plans. The Office of Inspector General safe harbor regulations clarify which payment practices are immune from prosecution.

HNS Compliance Policies for Contracted Health Care Professionals

7. Stark Law

Stark law is a set of federal laws that prohibit physician self-referral, specifically a referral by a physician of a Medicare or Medicaid patient to an entity providing designated health services (DHS) if the physician (or an immediate family member) has a financial relationship with that entity. A "financial relationship" includes ownership, investment interest, and compensation arrangements.

A. Contracted health care professionals shall not refer patients to an entity for a designated health service, as defined in 42 USC 1395nn(h)(6), if he/she or a member of his/her immediate family has a financial relationship with the entity, unless an exception applies.

B. Contracted health care professionals shall not present a claim to Medicare or to any person or other entity for a designated health service, as defined in 42 USC 1395nn(h)(6), provided under a prohibited referral.

HNS Compliance Policies for Contracted Health Care Professionals

C. Contracted health care professionals shall refund any amounts collected for designated health services, as defined in 42 USC 1395nn(h)(6), performed under a prohibited referral.

8. Federal Beneficiary Inducement Statute

(**waiving co-payments**)

Contracted health care professionals shall not knowingly influence a patient to select a particular provider or supplier by offering to waive or reduce co-payments and deductible amounts, or otherwise transfer an item or service for free or for other than fair market value. This includes offering discounts, professional courtesies, and services deemed TWIP (take what insurance pays).

(Violations of the Federal Beneficiary Inducement Statute may result in civil money penalties (CMPs) of up to **$10,000 for <u>each</u> wrongful act.**)

HNS Compliance Policies for Contracted Health Care Professionals

9. Civil Monetary Penalties

The Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities, as referenced in the policies below.

A. Contracted health care professionals shall not knowingly present or cause to be presented a claim for services not provided as claimed or which is otherwise false or fraudulent in any way.

B. Contracted health care professionals shall not offer or give remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services.

C. Contracted health care professionals shall not knowingly or willfully solicit or receive remuneration for a referral of a federal health care program beneficiary.

HNS Compliance Policies for Contracted Health Care Professionals

D. Contracted health care professionals shall not offer to transfer, or transfer, any remuneration to a beneficiary under a federal or state health care program, that the person knows or should know is likely to influence the beneficiary to order or receive any item or service from a particular provider, practitioner, or supplier, for which payment may be made, in whole or in part, under a federal health care program. Remuneration includes the waiver of coinsurance and deductible amounts except as otherwise permitted, and transfers of items or services for free or for less than fair market value.

10. Other FWA Laws

A. Contracted health care professionals shall comply with all fraud, waste, and abuse laws, the terms of their HNS Practitioner's Participation Agreement, the policies of HNS, policies of HNS' contracted health care plans, as well as rules and regulations issued by the physician's respective state licensing boards.

HNS Compliance Policies for Contracted Health Care Professionals

B. Contracted health care professionals shall not submit a claim for an item or service that is based on a code that the person knows or should know will result in greater payment than the code the person knows or should know is applicable to the item or service actually provided.

C. Contracted health care professionals shall not knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any health care benefit program.

D. Contracted health care professionals shall not knowingly and willfully execute, or attempt to execute, a scheme or artifice to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services.

HNS Compliance Policies for Contracted Health Care Professionals

E. Contracted health care professionals shall not knowingly and willfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program.

F. Contracted health care professionals shall not at any time knowingly and willfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment involving a federal or state health care program.

G. Contracted health care professionals shall not present or cause to be presented a claim for a physician's service knowing that the individual who furnished the service was not licensed as a physician.

H. Contracted health care professionals shall not submit a claim for physician services when rendered by a non-physician and require the physical presence of the physician, when the physician was not present, pursuant to the "incident to" rule.

HNS Compliance Policies for Contracted Health Care Professionals

11. Participation in Federal Health Care Programs

The Office of Inspector General (OIG) and Office of Personnel Management Office of Inspector General (OPM OIG) have authority to exclude from participation in federal health care programs *individuals and entities sanctioned for certain fraud, waste and abuse violations.* Federal agencies have general authority to debar or suspend individuals from work on government grants or contracts, or to provide services under federal health care programs like Medicare and Medicaid. **Once an individual or entity has been excluded or debarred from a federal or state health care program, no federal money may be used to pay for goods or services that the individual or entity provide.**

In addition, any entity that knowingly employs or contracts with an excluded or debarred individual or entity for the provision of goods or services may be subjected to civil monetary penalties.

HNS Compliance Policies for Contracted Health Care Professionals

A. Contracted health care professionals must ensure that their employees and applicable contractors are eligible for participation in federal health care plans (both at initial hire and monthly thereafter) by querying the OIG's List of Excluded Individuals & Entities (LEIE). Verification of eligibility can be obtained using via the following web address: http://exclusions.oig.hhs.gov/

B. Contracted health care professionals must retain documentation which substantiates that he/she conducted the initial and monthly reviews of the LEIE. This information must be available upon request by HNS, contracted health care plans, and CMS. These records must be maintained for 10 years.

C. Contracted health care professionals shall not contract with or employ any individual or entity:

- which has been excluded from participation in a federal or state health care program; or

- which has been convicted of a criminal offense related to the delivery of an item or service under any federal or state health care program; or

HNS Compliance Policies for Contracted Health Care Professionals

- which has been convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; or

- which has been convicted of an offense which occurred after August 21, 1996, under federal or state law, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service operated by or financed in whole or in part by any federal, state, or local government agency.

D. Contracted health care professionals shall not arrange for reimbursable services with an entity that is excluded from participation in a federal health care program.

E. Contracted health care professionals shall remove any personnel with pending criminal charges relating to health care, or proposed exclusion from participation in any federally or state funded health care program, from direct responsibility or involvement in any federally or state funded health care programs.

HNS Compliance Policies for Contracted Health Care Professionals

12. Documentation / Coding

Contracted health care professionals shall ensure that claims are only submitted for payment when the documentation in the health care record supports the services or items on the claim, and only when such documentation is legible, maintained, appropriately organized, and is available for audit and review.

Contracted health care professionals shall ensure that care provided to members of HNS contracted health care plans is provided and documented pursuant to the *HNS Clinical Records Quality Standards*. These standards are available on the HNS website.

Contracted health care professionals shall ensure that services billed through HNS are properly coded with the most appropriate and most current ICD, CPT, and/or HCPCS codes and, as applicable, are appended by appropriate modifiers, and that those codes are supported by documentation in the health care record.

HNS Compliance Policies for Contracted Health Care Professionals

13. Submission of Claims

Contracted health care professionals shall submit claims to HNS for all covered services provided to members whose health care plans contract with HNS. This includes claims for secondary coverage if the secondary payor contracts with HNS.

Exception: If a patient specifically requests that a contracted health care professional not file claims to their health care plan, the contracted health care professional shall comply with the request, but may do so ONLY if the applicable HNS Election Not to File form is signed and on file in the patient's health care record.

Contracted health care professionals shall ensure all services billed through HNS are consistent with HNS policies, the policies of contracted health care plans, the practice guides issued by the state licensing board in the state where the contracted health care professional practices, and all federal and state laws and regulations.

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals shall ensure all covered services billed, with the exception of maintenance and supportive care, are medically necessary, consistent with the documented chief complaint, clinical findings, diagnoses and treatment plan, and consistent with HNS' Medical Necessity Policy.

14. Use of Provider Name / NPI

Contracted health care professionals shall not knowingly misuse provider names or identification numbers. Only the name and the Type I NPI number of the provider who actually rendered the services must be included on claims. The provider's name is an attestation that he/she performed the services reported on the claim.

Exception: If services were provided by a locum tenens ("fill-in") provider and all locum tenens requirements have been met, services provided by the fill-in provider may be submitted under the name/NPI number of the provider who contracted with the fill-in provider. Additional information may be found in HNS' Locum Tenens Policy.

HNS Compliance Policies for Contracted Health Care Professionals

15. Unbundling

Contracted health care professionals shall not unbundle codes (use separate codes for services that have an aggregate code which should be used).

16. Duplicate Billing

Contracted health care professionals shall not submit duplicate billings in an attempt to gain duplicate payment.

17. Refunds / Overpayments

An overpayment is an improper or excessive payment made to a health care provider to which the provider is not entitled.

HNS Compliance Policies for Contracted Health Care Professionals

A. Contracted health care professionals shall not retain payments for health care services to which they are not entitled.

B. Contracted health care professionals shall ensure all payments, including zero dollar payments, are posted to patient accounts within 15 days of receipt.

C. Contracted health care professionals shall not, with knowledge and fraudulent intent, retain federal health care program or health care benefit program funds that have not been properly paid.

D. Contracted health care professionals shall ensure that overpayments/refunds are resolved pursuant to *HNS' Refund / Overpayment Policy*.

E. Contracted health care professionals who receive payment for services they did not provide or to which they are not *entitled*, shall immediately notify HNS (if the payment was issued by HNS) or the issuing entity (if not HNS) to arrange to repay those monies.

HNS Compliance Policies for Contracted Health Care Professionals

18. Compensation to Billing Personnel

(includes staff, billing companies, and/or consultants)

HNS contracted health care professionals shall not compensate billing staff and/or billing companies and/or consultants in a manner that provides financial incentive(s) to improperly code claims.

19. Non-Discrimination

Title I of the Americans with Disabilities Act (ADA) prohibits employment discrimination against individuals with disabilities and requires that employers reasonably accommodate the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless doing so would impose an undue hardship on the operation of the employer's business. *This section of the ADA applies to employers with 15 or more employees.*

HNS Compliance Policies for Contracted Health Care Professionals

Sections of The Patient Protection and Affordable Care Act (ACA) has placed additional requirements on covered entities related to discrimination in the health care arena. HNS has modified its Compliance Policies to ensure contracted health care professionals comply with these new regulations.

While contracted health care professionals must comply with all laws and regulations, this section of HNS' Compliance Policies focuses primarily on compliance to Section 504 of the Rehabilitation Act of the ADA and Section 1557 of the ACA.

Rehabilitation Act of the Americans with Disabilities Act (ADA)

Prohibits discrimination on the basis of disability in programs conducted by Federal agencies, in programs receiving Federal financial assistance, in Federal employment, and in the employment practices of Federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in Title I of the Americans with Disabilities Act.

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health care programs. Section 1557 makes it unlawful for any health care provider that receives funding from the Federal government to refuse to treat an individual or to otherwise discriminate against the individual based on race, color, national origin, sex, age, or disability.

HNS Compliance Policies for Contracted Health Care Professionals

HNS Policies:

1. Contracted health care professionals shall comply with all state and federal non-discrimination laws, including but not limited to, Title I of the Americans with Disabilities Act of 1990 (ADA), Rehabilitation Act of the ADA, and Section 1557 of the Patient Protection and Affordable Care Act (ACA).

2. Contracted health care professionals shall not discriminate on the basis of race, color, national origin, age, disability, or sex.

3. Contracted health care professionals shall not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

4. Contracted health care professionals shall make reasonable modification to their policies, procedures, and practices to provide individuals with disabilities access to their health programs and activities.

5. Contracted health care professionals shall take reasonable steps to provide meaningful access to individuals with limited English proficiency who are likely to be served under the physician's health care program.

HNS Compliance Policies for Contracted Health Care Professionals

Under the new ACA Non-Discrimination Rules, covered entities were required to post and publish mandatory non-discrimination statements and taglines by **October 17, 2016**.

HNS Compliance Policies for Contracted Health Care Professionals

HNS Policies:

1. **Notices of Non-Discrimination**
   Contracted health care professionals must display a non-discrimination notice stating its position against discrimination and which clarifies an individual's right to receive health care services in a non-discriminatory manner. (The statement of non-discrimination only has to be displayed in English.)

   The Notice of Non-Discrimination must indicate the health care professional:

   a. Provides information to patients in plain language and in a manner that is accessible and timely.

   b. Provides free services to people with disabilities to communicate effectively with us, including auxiliary aids.

   c. Provides free language assistance services to people whose primary language is not English.

HNS Compliance Policies for Contracted Health Care Professionals

This notice must be displayed:

a) In conspicuous, physical locations where the entity interacts with the public.

b) In a conspicuous location on the entity's website accessible from the home page of the website.

c) On significant publications and communications targeted to members of the public.

HNS Compliance Policies for Contracted Health Care Professionals

Covered entities are in the best position to determine, within reason, which of their communications and publications *are significant* in the context of their own health programs and activities. Examples of publications and communications that OCR considers to be "significant" include applications to participate in, or receive benefits or services from, a covered entity's health program or activity, as well as written correspondence related to an individual's rights, benefits, or services, ***including communications which require a response.***

(Significant communications and publications do NOT include marketing and advertising materials.)

HNS Assistance: HNS has prepared a sample "non-discrimination" notice, which includes patient's rights to assist with compliance to the above requirements. This document, titled "*Statement of Non-Discrimination*" is posted under the Compliance Section of the HNS website, as well as in the ***HNS Forms*** section of the website.

HNS Compliance Policies for Contracted Health Care Professionals

2. Consumer Assistance (Consumers with LEP)

HNS Policies:

A. Contracted health care professionals are responsible for providing timely and accurate language assistance services, including oral interpretation and written translation, in non-English, when doing so is a reasonable step to provide meaningful access to an individual with limited English proficiency.

An individual with limited English proficiency is a person whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

B. Taglines: Contracted health care professionals must advise consumers of the availability of free language assistance services, *in the top 15 languages spoken by individuals with LEP*, in the states in which the covered entity operates. (The top 15 languages spoken in NC and SC are posted on the HNS website under the Compliance section.) These “taglines” must be posted in specific locations and on certain documents.

HNS Compliance Policies for Contracted Health Care Professionals

Taglines must be displayed:

a) In conspicuous, physical locations where the entity interacts with the public.

b) In a conspicuous location on the entity's website accessible from the homepage of the website and included in any other website content which is *critical* for obtaining access to health care. **(See information below regarding "critical".)**

c) On large and significant publications and communications targeted to members of the public if such documents or publications are *critical* for obtaining access to health care. *(Significant communications and publications do NOT include marketing and advertising materials.)*

d) For smaller documents or communications, contracted health care professionals are only required to provide taglines in the top two (2) languages spoken by individuals with LEP.

HNS Compliance Policies for Contracted Health Care Professionals

Critical:

45 CFR 155.205 states: "A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee."

More about "Critical Documents"

HNS contracted health care professionals must, at a minimum, ensure taglines are included in the following essential documents:

- Informed consent forms
- All documents that require a signature or response from the patient or his/her legal guardian.

HNS Compliance Policies for Contracted Health Care Professionals

(Per HHS – Notices of Privacy Practices (HIPAA) are NOT required to include taglines.)

HNS Assistance: HNS has prepared taglines in the top 15 languages spoken in NC and SC for contracted health care professionals to use to comply with this requirement. These taglines are posted under the Compliance section of the HNS website, as well as in the HNS Forms section of the website. Prior to publication, providers must insert their names or practice names, as well as the office phone number in each applicable place in the taglines.

HNS Compliance Policies for Contracted Health Care Professionals

C. Oral Interpretation: Contracted health care professionals shall make oral interpretation available to consumers with LEP and must do so *at no charge to the consumer.* (Neither family members nor friends may substitute for translators, the translators must be "qualified".)

HNS Assistance: To help you meet this requirement, HNS has contracted with CyraCom® to provide you with free, in-office telephonic interpretation services in over 200 languages. CyraCom® is the largest provider of interpretation services that operates solely in the US, and the 2nd largest provider worldwide.

(Contracted health care professionals must register with HNS for access to this free service. To register, please refer to the *Interpretive Services (CyraCom®)* page of the HNS website, under ***Cultural Competency***.

HNS Compliance Policies for Contracted Health Care Professionals

D. Written translation: Contracted health care professionals shall make written translations available for:

- Written materials that will be given to patients which are *critical* for obtaining *access to health care services*.
- Written translation must be provided by a qualified translator.

Note:

There are many organizations which provide written translation services, including **CyraCom®**. *However, costs for translation of written materials are not included in the HNS contract with CyraCom®.*

HNS Compliance Policies for Contracted Health Care Professionals

3. Consumer Assistance (Consumers with Disabilities)

HNS Policies:

Contracted health care professionals shall ensure individuals with disabilities have access to a covered entity's health programs and activities, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act and the ACA.

Contracted health care professionals shall make reasonable modifications to their policies, procedures, and practices to provide individuals with disabilities access to their health programs and activities unless it would result in a fundamental alteration of the program.

Contracted health care professionals shall ensure communication assistance to consumers with disabilities, *including the provision of auxiliary aids and services* (at no additional cost to the consumer).

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals shall:

- Provide notice that indicates:
  - That it does not discriminate on the basis of disability
  - How to contact the employee who coordinates efforts to comply with the law
  - Information about the grievance procedures
- Provide services and programs in the most integrated setting appropriate to the needs of the qualified individual with a disability.
- Ensure that programs, services, activities, and facilities are accessible.

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals shall:

- Designate a responsible employee to coordinate their efforts to comply with applicable laws (if the health care professional employs 15 or more employees).
- Make websites and electronic information accessible to individuals with disabilities unless doing so would result in an undue financial and administrative burden, or a fundamental alteration in the nature of the physician.
- Adopt grievance procedures to handle complaints of disability discrimination in their programs and activities.

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals shall not on the basis of disability:

- Exclude a person with a disability from a program or activity.
- Deny a person with a disability the benefits of a program or activity.
- Afford a person with a disability an opportunity to participate in or benefit from a benefit or service that is not equal to what is afforded others.
- Provide a benefit or service to a person with a disability that is not as effective as what is provided others.
- Provide different or separate benefits or services to a person with a disability unless necessary to provide benefits or services that are as effective as what is provided others.
- Apply eligibility criteria that tend to screen out persons with disabilities unless necessary for the provision of the service, program, or activity.

HNS Compliance Policies for Contracted Health Care Professionals

20. Monitoring / Auditing

Contracted health care professionals shall conduct periodic auditing and monitoring to assist in the detection of non-compliance to laws and regulations and these policies.

21. Investigating / Correcting Non-Compliance

Contracted health care professionals shall promptly investigate all suspected or known instances of non-compliance.

Contracted health care professionals shall promptly correct all known instances of non-compliance.

HNS Compliance Policies for Contracted Health Care Professionals

22. Reporting Non-Compliance

Contracted health care professionals shall report to HNS, and as applicable, appropriate government authorities, all suspected or actual instances of non-compliance, and shall promptly report and escalate any incidents of suspected fraud, waste and abuse.

23. Cooperating with Compliance Investigations

HNS contracted health care professionals shall cooperate fully with any compliance investigation initiated by HNS, by contracted health plans, government or regulatory bodies, or as otherwise required by law.

HNS Compliance Policies for Contracted Health Care Professionals

24. Records

Contracted health care professionals shall maintain records in accordance with state and federal laws and regulations and HNS Policies.

Relative to records relating to Qualified Health Plans, contracted health care professionals shall retain and grant access to their books, records, contracts, computers or other electronic systems to Qualified Health Plans and/or Department of Health and Human Services and its Office of Inspector General, or their designees, for the duration of the physician's participation in the HNS Network, and for a period of at least ten (10) years from the date participation in the HNS Network ends.

HNS Compliance Policies for Contracted Health Care Professionals

Contracted health care professionals must retain complete patient health care records (including EOBs) for a minimum of 10 years from last date of service, OR, if the patient is a minor, for 10 years after the minor patient reaches age 19. Once the patient reaches 19 and is still under care, the contracted health care professional should retain the patient health care record for 10 years from the last date of service. The patient health care record must be maintained in a safe and secure location.

Contracted health care professionals shall maintain records in a safe, secure place and implement appropriate safeguards, as applicable, to protect the privacy and security of the records, in accordance with applicable laws, regulations, and contractual obligations.

Enforcement of Standards and Policies

By enforcing compliance to HNS' policies, HNS seeks to prevent accidental and intentional non-compliance with applicable laws, to detect such non-compliance if it occurs, to discipline those involved in non-compliant behavior, to remedy the effects of non-compliance, and to prevent repeat non-compliance.

If a material violation of applicable law, regulations, and/or HNS Compliance Policies occurs, HNS is committed to taking appropriate steps to correct the problem, including appropriate disciplinary actions.

HNS reserves the right to modify its sanction policies at any time and will provide timely notification to contracted health care professionals of any material changes.

Application of Sanctions

The review of misconduct and the imposition of sanctions for contracted health care professionals shall be the responsibility of HNS' Compliance Officer and CEO.

Written notifications of sanctions/disciplinary actions will be communicated to the individual engaged in the misconduct and will include the misconduct, and as applicable, may include a summary of the results of the investigation.

Disciplinary Action

If HNS concludes that an individual has violated laws, regulations, or HNS Policies, the individual will be subject to appropriate disciplinary action.

Disciplinary measures will be taken on a case-by-case basis. HNS reserves the right to apply sanctions at its discretion, based on the seriousness of the misconduct, but all disciplinary action will be applied on an equitable basis.

Enforcement and discipline may include discipline of individuals *who fail to report suspected or known non-compliant conduct,* and/or who fail to fully cooperate with compliance investigations.

Any combination of the following sanctions
may be applied for misconduct relating to non-compliance.

Disciplinary Action

Sanctions for <u>Negligent</u> Action - First or Second Offense

- Issuing verbal or written warning;
- Requiring additional compliance training or other educational requirements;
- Requiring the completion and submission of a corrective action plan (CAP);
- Temporarily suspending the health care professional's access to *HNSConnect*® or his/her ability to submit claims to HNS via Office Ally™;
- Auditing of patient health care and financial records; and/or
- Placing the health care professional on probationary status with HNS.

Disciplinary Action

Sanctions for <u>Negligent</u> Action - Third Offense

- Requiring additional compliance training or other educational requirements;
- Requiring the completion and submission of a corrective action plan (CAP);
- Temporarily suspending the health care professional's access to *HNSConnect*® or his/her ability to submit claims to HNS via Office Ally™;
- Auditing of patient health care and financial records;
- Terminating the health care professional from the network; and/or
- Reporting the misconduct to the appropriate federal and state authorities, including, but not limited to, state licensing boards and the National Practitioner's Data Bank (NPDB), as well as contracted health care plans.

Disciplinary Action

Sanctions for <u>Intentional</u> Action - First Offense

- Requiring additional compliance training;
- Requiring the completion and submission of a corrective action plan (CAP);
- Temporarily suspending the health care professional's access to *HNSConnect*® or his/her ability to submit claims to HNS via Office Ally™;
- Auditing of patient health care and financial records;
- Placing the health care professional on probationary status with HNS;
- Terminating the health care professional from the network;
- Reporting the misconduct to the appropriate federal and state authorities, including but not limited to, state licensing boards and the National Practitioner's Data Bank (NPDB), as well as contracted health care plans; and/or
- Prosecuting the individual.

Disciplinary Action

Sanctions for <u>Intentional</u> Action - Second Offense

- Terminating the health care professional from the network;
- Reporting the misconduct to the appropriate federal and state authorities, including but not limited to, state licensing boards and the National Practitioner's Data Bank (NPDB), as well as contracted health care plans; and/or
- Prosecuting the individual.

Non-Compliance

Non-Compliance

Non-compliance is conduct
that does not conform to the law,
federal health care program requirements, or to an
organization’s ethical, business, and compliance policies.

Investigating Non-Compliance

HNS will investigate all bona fide complaints of known or suspected violations by contracted health care professionals.

Contracted health care professionals must cooperate fully with any compliance investigation undertaken by HNS' Compliance department, any contracted health care plan, and/or governmental agency.

Duty to Report Violations
(FWA, HIPAA & Standards of Conduct)

You have a **duty to report**
and immediately escalate any incidents of potential non-compliance or suspected fraud, waste and abuse.

Contracted health care professionals who fail to report suspected or known non-compliant conduct will be subject to HNS' Disciplinary Actions and Sanction Policies.

How to Report Violations

Report known or suspected violations to HNS.

Via email: HNSCompliance@healthnetworksolutions.net

OR

Contact the HNS Compliance Officer
at (877) 426-2411, ext. 2

How to Report Violations

You may also report violations to one or more of the following appropriate federal and state authorities:

US Office of Inspector General (OIG)
(FWA violations)
Compliance Hotline: 1-800-447-8477

Centers for Medicare and Medicaid (CMS)
(FWA violations)
Compliance Hotline: 1-800-MEDICARE
1-800-633-4227 or 1-877-486-2048

Secretary, Department of Health and Human Services
Office of Civil Rights (OCR)
(HIPAA violations)
http://www.hhs.gov/ocr/privacy/hipaa/complaints

Confidentiality / No Retaliation

Confidentiality of Identity of Reporting Individual
When reporting suspected or known violations you may remain anonymous if you choose. Anyone reporting non-compliance is assured that such reports will be treated with appropriate confidentiality.

Whistle Blower Protection
Federal and state laws contain **protections** for “whistleblowers” who alert the appropriate governmental authority of a violation of laws. Under these laws, any person with actual knowledge of an allegedly false claim, including employees, may, under certain conditions, notify the appropriate state or federal governmental authorities about potential violations, without fear of retaliation. Whistleblowers may also be entitled to relief, including employment reinstatement, back pay, and other compensation arising from retaliatory conduct against him or her.

Correcting Non-Compliance

Correcting non-compliance
helps to avoid the recurrence of the same
non-compliant behavior/conduct, and promotes efficiency and
effective internal controls.

Penalties for Non-Compliance

HNS takes our compliance responsibilities seriously. Failure to comply with HNS Compliance Policies and the policies of contracted health care plans will subject contracted health care professionals to disciplinary action by HNS, up to and including termination of their Practitioner's Participation Agreement.

Additionally, health care professionals who violate laws and regulations risk individual criminal prosecution and penalties, civil actions for damages and penalties, and exclusion from federal and private health care programs.

Questions about Non-Compliance

Despite best efforts by each of us to comply with applicable laws, inevitably there will be questions about the appropriateness of a behavior, action, or practice by ourselves, our employees, and/or our colleagues.

HNS is here to help!

If you have questions regarding the information presented in this training module, or whether certain conduct should be reported, please contact the HNS Compliance Officer.

HNSCompliance@HealthNetworkSolutions.net

or

(877) 426-2411, ext. 2

Summary

All of us must conduct business in accordance with the highest ethical standards and in accordance with federal and state laws and regulations and policies which govern our industry.

Compliance training helps us meet this objective by increasing awareness of our legal environment and by helping us detect and prevent violations of laws applicable to our industry.

Remember:
Prevent, Detect, Report, and Correct Non-Compliance!

Putting It All Together...

This concludes the portion of this training developed by HNS.

The following slides are from CMS' Compliance Training module and are required to be included in the HNS Compliance Training.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Part 2: Medicare Parts C & D Compliance Training

Developed by the Centers for Medicare & Medicaid Services

IMPORTANT NOTICE

This training module will assist Medicare Parts C and D plan Sponsors in satisfying the Compliance training requirements of the Compliance Program regulations at 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and in Section 50.3 of the Compliance Program Guidelines found in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

While Sponsors may choose to use this module to satisfy compliance training requirements, completion of this training in and of itself does not ensure that a Sponsor has an "effective Compliance Program." Sponsors are responsible for ensuring the establishment and implementation of an effective Compliance Program in accordance with CMS regulations and program guidelines.

Why Do *I* Need Training?

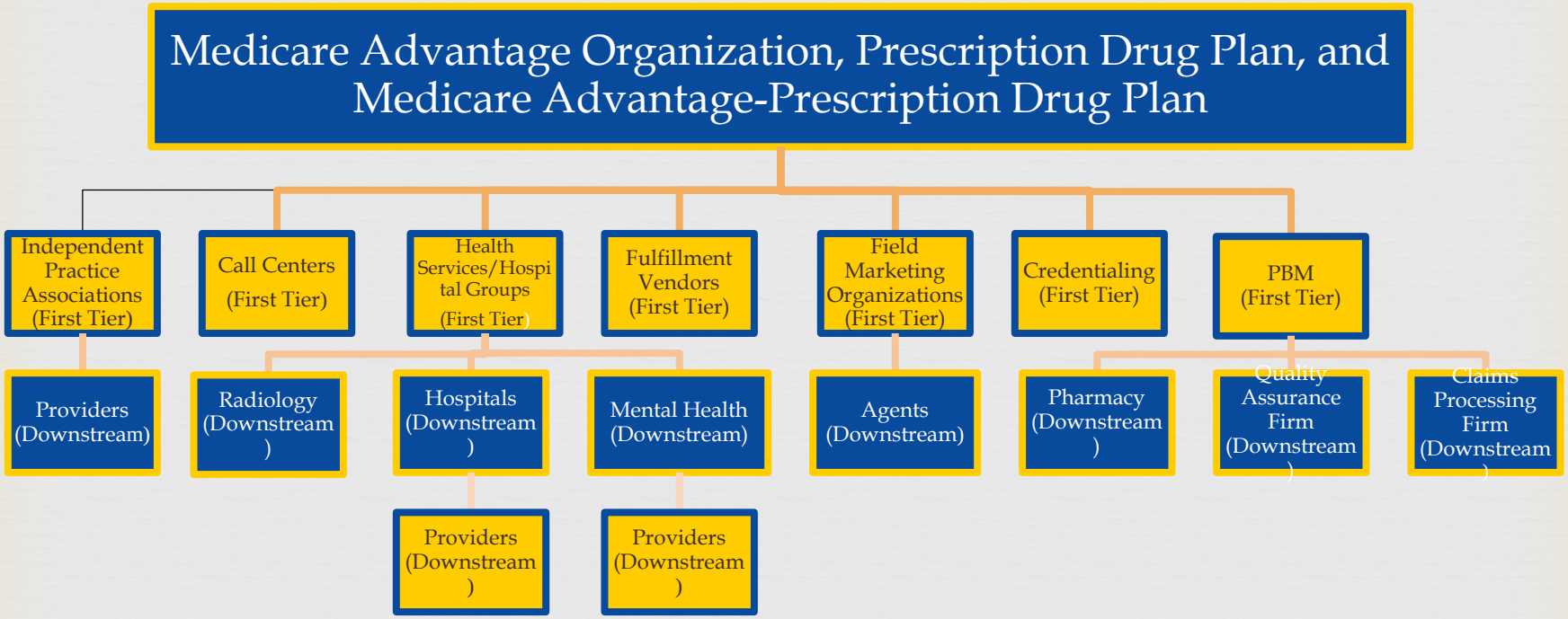
Compliance is EVERYONE'S responsibility!

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.

Training Objectives

- To understand the organization's commitment to ethical business behavior
- To understand how a compliance program operates
- To gain awareness of how compliance violations should be reported

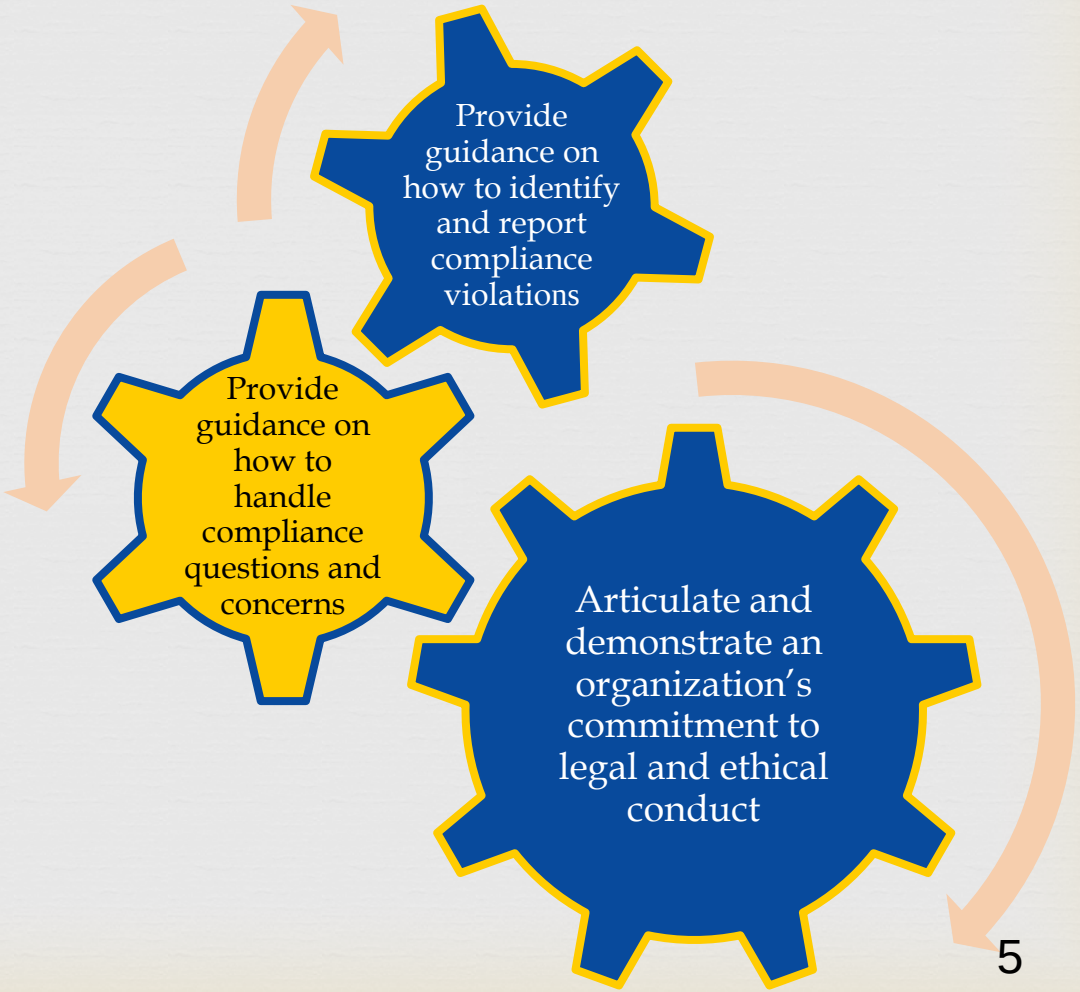
Where Do I Fit in the Medicare Program?



Background

- CMS requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors ("Sponsors") to implement an effective compliance program.

- An effective compliance program should:



Compliance

A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance

Compliance Program Requirements

At a minimum, a compliance program must include the 7 core requirements:

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 and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

Compliance Training

- CMS expects that all Sponsors will apply their training requirements and "effective lines of communication" to the entities with which they partner.

- Having "effective lines of communication" means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

Ethics – Do the Right Thing!

Act Fairly and Honestly

Comply with the letter and spirit of the law

As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner.

It's about doing the right thing!

Adhere to high ethical standards in all that you do

Report suspected violations

How Do I Know What is Expected of Me?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates.

Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations.

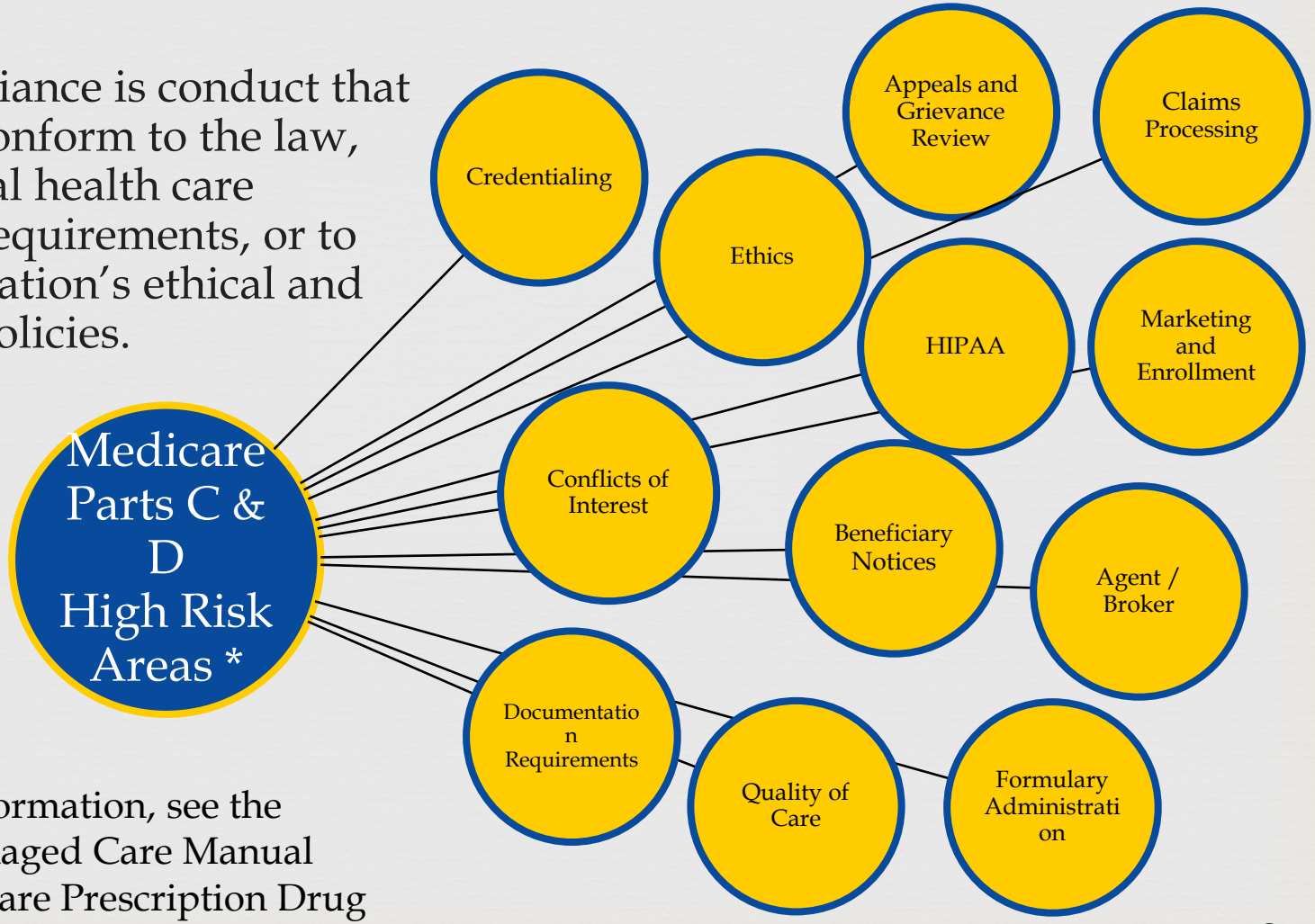
How Do I Know What is Expected of Me (cont.)?

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

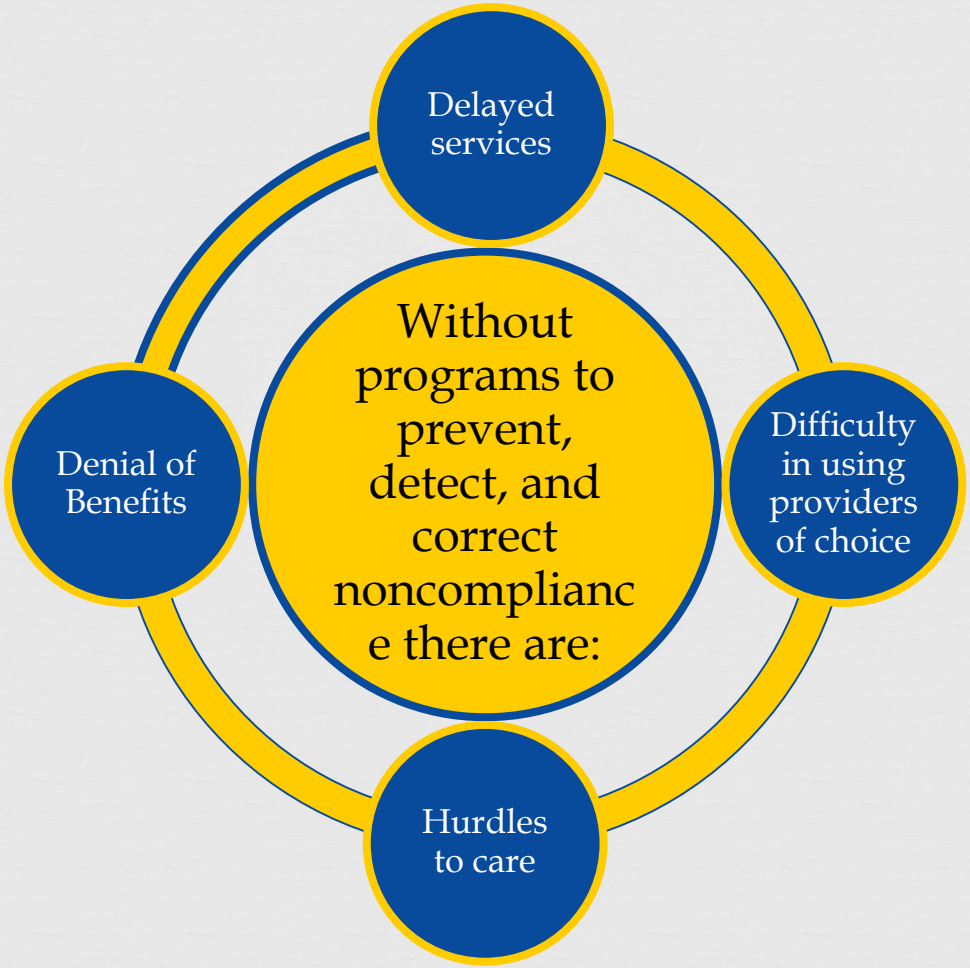
What Is Noncompliance?

Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization's ethical and business policies.



* For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual on http://www.cms.gov

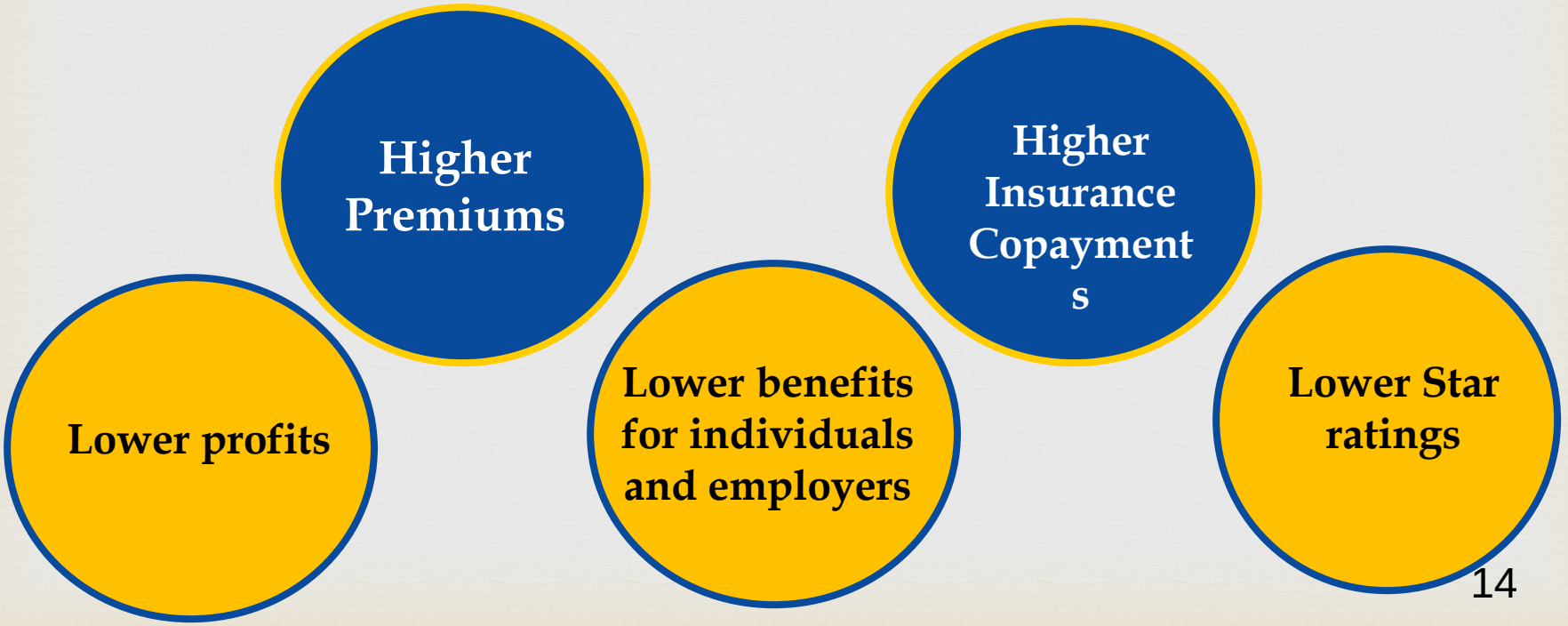
Noncompliance Harms Enrollees



Noncompliance Costs Money

Non Compliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:



I'm Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

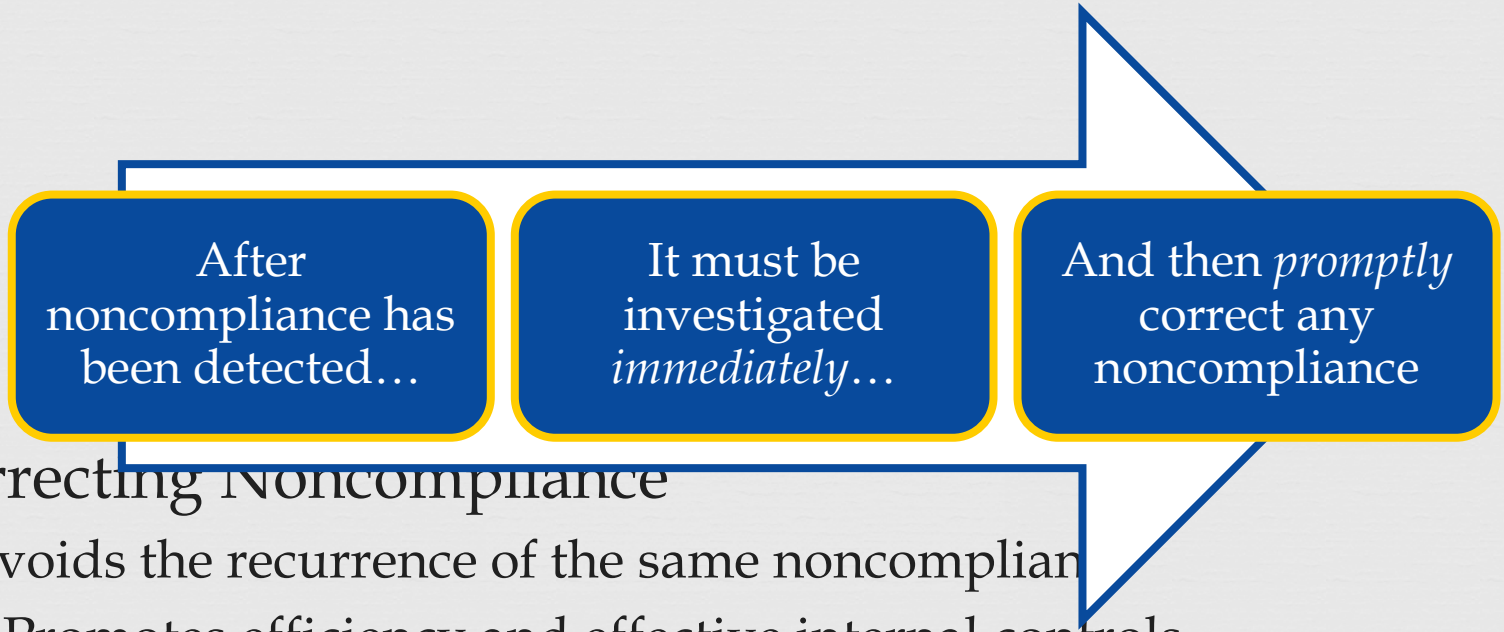
Each Sponsor must offer reporting methods that are:

- Confidential
- Anonymous
- Non-Retaliatory

How Can I Report Potential Noncompliance?

Employees of an MA, MA-PD, or PDP Sponsor	• Call the Medicare Compliance Officer • Make a report through the Website • Call the Compliance Hotline
FDR Employees	• Talk to a Manager or Supervisor • Call Your Ethics/Compliance Help Line • Report through the Sponsor
Beneficiaries	• Call the Sponsor's compliance hotline • Make a report through Sponsor's website • Call 1-800-Medicare

What Happens Next?

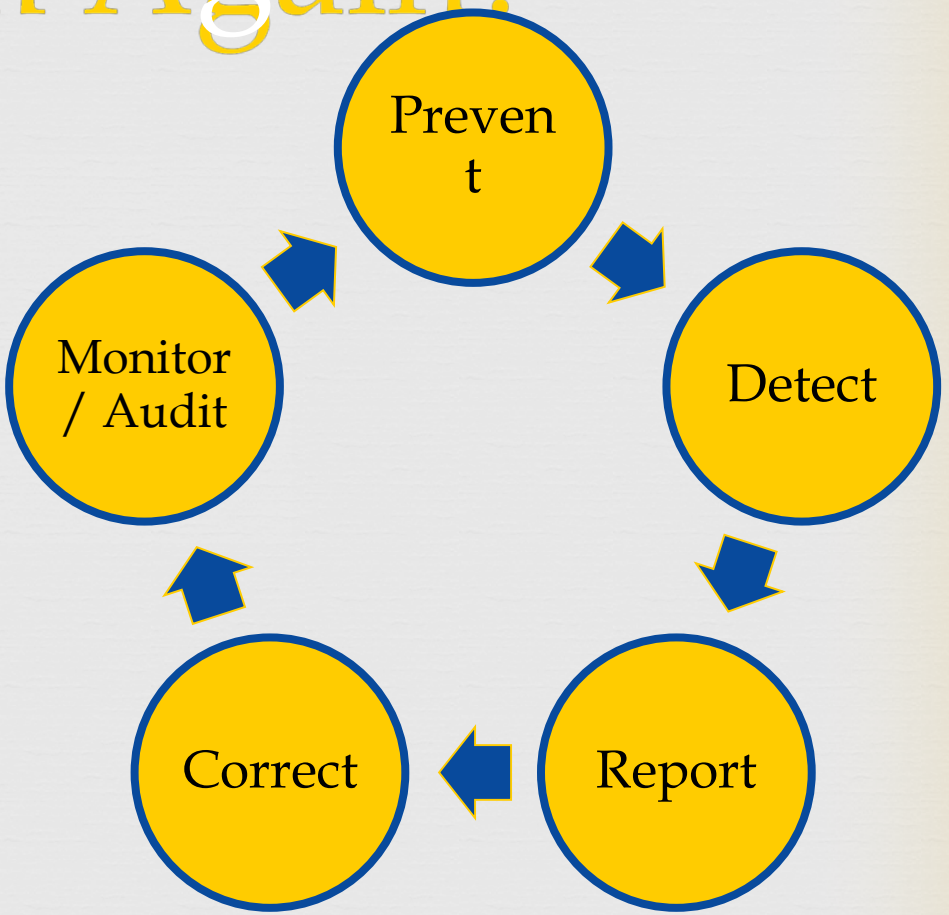


Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
  - Promotes efficiency and effective internal controls
    - Protects enrollees
      - Ensures ongoing compliance with CMS requirements

How Do I Know the Noncompliance Won't Happen Again?

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures



Know the Consequences of Noncompliance

Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:

Compliance is EVERYONE'S Responsibility!!

PREVENT

- Operate within your organization's ethical expectations to PREVENT noncompliance!

DETECT & REPORT

- If you DETECT potential noncompliance, REPORT it!

CORRECT

- CORRECT noncompliance to protect beneficiaries and to save money!

Scenario 1

You have discovered an unattended email address or fax machine in your office which receives beneficiary appeals requests.

You suspect that no one is processing the appeals. What should you do?

Scenario 1

A) Contact Law Enforcement
B) Nothing
C) Contact your Compliance Department
D) Wait to confirm someone is processing the appeals before taking further action
E) Contact your supervisor

Scenario 1

The correct answer is: C – Contact your Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

Your Sponsor's compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Sponsor's Standards of Conduct and Policies and Procedures.

Scenario 2

A sales agent, employed by the Sponsor's first-tier or downstream entity, has submitted an application for processing and has requested two things:

i) the enrollment date be back-dated by one month

ii) all monthly premiums for the beneficiary be waived

What should you do?

Scenario 2

A) Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department

B) Make the requested changes because the sales agent is responsible for determining the beneficiary's start date and monthly premiums

C) Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions). You will not file a report because you don't want the sales agent to retaliate against you

D) Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

E) Contact law enforcement and CMS to report the sales agent's behavior.

Scenario 2

The correct answer is: D - Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

The enrollment application should be processed in compliance with CMS regulations and guidance. If you are unclear about the appropriate procedure, then you can ask your supervisor or the compliance department for additional, job-specific training.

Your supervisor and the compliance department should be made aware of the sales agent's request so that proper retraining and any necessary disciplinary action can be taken to ensure that this behavior does not continue. *No one*, including the sales agent, your supervisor, or the Compliance Department, can retaliate against you for a report of noncompliance made in good faith.

Scenario 3

You work for an MA-PD Sponsor. Last month, while reviewing a monthly report from CMS, you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan.

You spoke to your supervisor, Tom, who said not to worry about it. This month, you have identified the same enrollees on the report again.

What do you do?

Scenario 3

A) Decide not to worry about it as your supervisor, Tom, had instructed. You notified him last month and now it's his responsibility.

B) Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

C) Wait until next month to see if the same enrollees are on the report again, figuring it may take a few months for CMS to reconcile its records. If they are, then you will say something to Tom again.

D) Contact law enforcement and CMS to report the discrepancy.

E) Ask Tom about the discrepancies again.

Scenario 3

The correct answer is: B - Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

There can be no retaliation for reports of noncompliance made in good faith. To help promote reporting, Sponsors should have easy-to-use, confidential reporting mechanisms available to its employees 24 hours a day, 7 days a week.

It is best to report any suspected noncompliance to the Compliance Department promptly to ensure that the Sponsor remains in compliance with CMS requirements. Do the right thing! Compliance is everyone's responsibility.

What Governs Compliance?

- **Social Security Act:**
  - Title 18
- **Code of Federal Regulations*:**
  - 42 CFR Parts 422 (Part C) and 423 (Part D)
- **CMS Guidance:**
  - Manuals
  - HPMS Memos
- **CMS Contracts:**
  - Private entities apply and contracts are renewed/non-renewed each year
- **Other Sources:**
  - OIG/DOJ (fraud, waste and abuse (FWA))
  - HHS (HIPAA privacy)
- **State Laws:**
  - Licensure
  - Financial Solvency
  - Sales Agents

** 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)*

Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
  - OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

Congratulations!

You have successfully completed HNS' and CMS (Part C & D) FWA/Compliance Training.

Please sign and date the Compliance Training Certificate (next slide) and **fax or email ONLY the physician's certificate to HNS**.

As a final reminder, be sure to
save a copy of this training module and your signed certificate, as you are required to produce these if requested by HNS, CMS or other regulatory bodies.

HNS
Compliance Training Certification

I certify that I have completed the HNS and CMS (Part C & D) Compliance Training Module.

I understand my responsibility to comply with the requirements addressed in this training module as well as my responsibility to comply with *HNS Compliance Policies for Contracted Health Care Professionals.*

Further, I understand my responsibility to save this certificate, as well as a copy of this training module, for a period of no less than **10 years** from the date shown below.

_____ _____

Name (please print) Signature

_____

Date of Training

You must retain this form AND a copy of this training module for 10 years.

x046