18 – Fraud, Waste and Abuse Compliance Policy

Activities that are considered fraud, waste and abuse by members, practitioners or care providers hurts everyone – SHL, taxpayers, members, and providers. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud or abuse. Your assistance in notifying us and cooperating with any potential fraud or abuse occurrence is vital and appreciated in conjunction with our mutual ongoing efforts to coordinate the most effective health outcomes possible for our members.

Definitions of Fraud, Waste and Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

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

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to health insurance plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Examples of Potentially Fraudulent, Wasteful or Abusive Billing include, but are not limited to:

- **Back filling:** Billing for part of the global fee before the claim is received for the actual global code.
- **Billing for services not rendered:** Billing for services or supplies that were not provided to the member.
- **Billing for unauthorized services or equipment:** Billing for ancillary, therapeutic or other services without a required physician’s order.
- **Billing while ineligible:** Billing for services after health care provider’s license has been revoked/restricted or after a health care provider has been debarred from a government benefits program for fraud or abuse.
- **Double billing:** Billing more than once for the same service.
- **Falsified documents:** Submitting falsified or altered claims or supporting claims with falsified or altered medical records and/or supporting documentation and amending or correcting medical records or claims significantly after the date of service.
- **Looping:** Submitting claims for various family members when only one member is receiving services.
- **Misrepresentation:** Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for non-covered services.

- **Patient brokering:** Using “brokers” who offer money to subscribers for the use of their ID cards.
- **Phantom billing:** Billing by a “phantom” or non-existent health care provider for services not rendered.
- **Unbundling:** Billing each component of a service when one comprehensive code is available.
- **Up-coding:** Billing at a higher level of service than was actually provided.
- **Waiver of copay:** Choosing not to collect copayments or deductibles.

If you identify potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. There are multiple reporting methods including:

SHL Provider Services - 702-242-7088
The Compliance & Ethics Help Center
–Phone: 1-800-455-4521 (US)
–Online: www.uhghelpcenter.ethicspoint.com
–The Help Center is available 24 hours a day, 7 days a week.
Health Care Fraud Tip Line
-Phone: 1-866-242-7727
-Email: UHCNV-Medic-FWA@uhc.com
UnitedHealth Group Compliance & Ethics Office
–Phone: 1-952-936-7463
–Email: ethicsoffice@uhg.com

Prevention and Detection

We help prevent and detect potential FWA through many sources. These include:
• UnitedHealthcare Payment Integrity functions
• Optum Companies within UnitedHealth Group
• Health care providers
• Health plan members
• Federal and state regulators and task forces
• News media
• Professional anti-fraud and compliance associations
• CMS Web Sites: https://sam.gov/SAM/

We also monitor and audit prevention and detection by:
Prospective Detection:
• Pre-Payment Data Analytics
• Data Mining Queries
• Abnormal Billing Patterns
• Other activities to determine if we need additional prospective activities
Retrospective Detection:
• Post-Payment Data Analytics
• Payment Error Analytics
• Industry Trend Analysis
• Care Provider Audits

Corrective Action Plans

As a part of our payment integrity responsibility, we evaluate the appropriateness of paid claims. We may initiate a formal corrective action plan if a provider does not comply with our billing guidelines or performance standards. We will monitor the plan to confirm that it is in place and address any billing/performance problems.

Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of HIPAA. The law makes it illegal to offer money, or services that are likely to influence a member to select a particular care provider, practitioner, or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment
- Waiving copayments and deductibles

Health care providers who violate this law may be fined up to $10,000 for each item or service for which payment may be made, and $5,000 for each individual violation. Fines may be assessed for up to 3 times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities

Items or services offered to members for free must be worth less than $15 and total less than $75 per year per beneficiary. Never give cash or gift cards to members.

Required Training

As part of an effective Compliance Program, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including SHL, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their employees, including the CEO, senior administrators or managers, and for governing body members, and for first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties. As a delegate that performs administrative or health care services, CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements.

FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. Our expectation remains that FDRs and their employees are sufficiently trained to identify, prevent and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers and sub delegates who are involved in or responsible for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

We have general compliance training and FWA resources available at unitedhealthgroup.com. The required education, training and screening requirements include the following:

Standards of Conduct Awareness

FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group's (UHG's) Code of Conduct (found at https://www.unitedhealthgroup.com/content/dam/UHG/PDF/About/UNH-Code-of-Conduct.pdf) to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

What You Need to Do for Standards of Conduct Awareness

Provide your own or the UHG's Code of Conduct as outlined above and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste, and Abuse and General Compliance Training

FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide Fraud, Waste, and Abuse (FWA) and General Compliance training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of Sierra Health & Life benefits or services.

Effective January 1, 2016, CMS requires the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization. The CMS standardized FWA training and education module is available through the CMS Medicare Learning Network (MLN) at cms.gov.

FDRs meeting the FWA certification requirements through enrollment in the fee-for-service (Parts A or B) Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

What You Need to Do for FWA and Compliance Training

Administer FWA and General Compliance training as outlined above and maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), employee attestations or electronic certifications from employees that include the date of the training) for 10 years. Documentation may be requested by Sierra Health & Life or CMS to verify compliance with this requirement.

Exclusion Checks

FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers, volunteers, and consultants), the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of Sierra Health & Life benefits or services to make sure that none are excluded or become excluded from participating in Federal health care programs.

FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at http://oig.hhs.gov/exclusions/index.asp

General Services Administration (GSA) Excluded Parties Lists System at https://www.sam.gov

What You Need to Do for Exclusion Checks

Review applicable exclusion lists as outlined above and maintains a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by Sierra Health & Life or CMS to verify that checks were completed.

Preclusion list policy

The CMS has a Preclusion List effective for claims with dates of service on or after April 1, 2019. The Preclusion List applies to MA plans as well as Part D plans.

The Preclusion List is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.

Health care providers receive a letter from CMS notifying them of their placement on the Preclusion List. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with HPN. CMS updates the Preclusion List monthly and notifies MA and Part D plans of the claim-rejection date, the date upon which we reject or deny a health care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded health care provider's claims will no longer be paid, pharmacy claims will be rejected, and the health care provider will be terminated from the HPN network. Additionally, the precluded health care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim-rejection date.

As contracted health care providers of HPN, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information on the Preclusion List, visit cms.gov.