GOVERNMENT PROGRAMS COMPLIANCE OFFICER NEWSLETTER

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HEALTH CARE SERVICE CORPORATION

Message from Kim Green
HCSC Government Programs Compliance Officer

Welcome to our first quarterly newsletter for 2013!

Last year, we briefly discussed Fraud, Waste and Abuse (FWA) within the Medicare and Medicaid programs. Health care fraud, waste and abuse can be committed by anyone from providers to members, pharmacies and others. Medicare and Medicaid lose billions of dollars to fraudulent claims every year. Eliminating fraud cuts costs for families impacted by government programs, businesses, and the federal government. As you are already aware, HCSC is committed to the prevention, early detection and resolution of fraud, waste and abuse.

Inside this newsletter you will find information about how the Centers for Medicare & Medicaid Services (CMS) defines FWA, various FWA examples and laws that are designed to help combat this issue.

HCSC believes that each employee, other individuals and our contracted entities who work with the Medicare and Medicaid programs are crucial to preventing FWA. It is important to recognize that compliance is everyone's responsibility and not just the task of the Government Programs Compliance department. We all have a role to play in maintaining an effective government compliance program.

Please remember that you are required to report any suspicious behavior or potential wrongdoing related to any government contract. All calls to our hotline can be made anonymously and without fear of intimidation or retaliation.

Our Medicare and Fraud hotline numbers and email address are also included in this newsletter so that you may contact us should you have any questions or concerns. As the Government Program's Compliance Officer, please know that you can always contact me directly at 312-653-5110.

We encourage you to visit our website and submit any general questions or news items that you would like hear about in future newsletters.

We hope that you enjoy this newsletter!

Kim Green

HCSC Government Programs Compliance Officer

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Medicare Compliance Issues?

Contact HCSC Medicare Hotline 1.877.211.2290

Your 24/7 resource for questions about Medicare Part D or MAPD

Fraud, Waste and Abuse (FWA) defined

Fraud: a type of illegal act involving the obtaining of something of value through willful misrepresentation. Whether an act is, in fact, fraud is a determination to be made through the judicial system. **Example:** A provider bills a member or a health plan for a service that was never performed.

Waste: involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. **Example**: A provider prescribes a prescription with refills without taking into account if the refills are needed.

Abuse: involves behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary business practice given the facts and circumstances. Abuse also includes misuse of authority or position for personal financial interests or those of an immediate or close family member or business associate. Abuse does not necessarily involve fraud, violation of laws, regulations, or provisions of a contract or grant agreement. **Example:** A provider submits reimbursement for services that are not medically necessary.

Federal and State Laws Related to FWA

Anti-Kickback Statute

The “Anti-Kickback Statute” prohibits any person from knowingly and willfully soliciting or receiving any remuneration (including kickbacks, bribes or rebates) directly or indirectly, in return for patient referrals or purchasing, leasing, ordering, arranging for, or recommending any goods, facility, service or item(s) which are reimbursable under Medicare, Medicaid, or state health care programs.

The Anti-Kickback Statute prohibits not only "soliciting or receiving" a kickback or remuneration, it also prohibits anyone from offering or paying one.

A kickback is not limited to cash referral fees; “in kind” payments for having received special consideration in the purchase of items or in the making of referrals will qualify as a kickback

Health Insurance Portability and Accountability Act (HIPAA)

Federal law that provides for the portability of health insurance coverage, the privacy of personal health information and the standardization of electronic claims data among health insurance companies and providers.

Federal and State False Claims Act

The Federal Government, as well as most State Governments, has enacted laws known as "False Claims" Acts. In general, these laws allow for significant criminal and civil penalties for any person or entity who knowingly submits a false or fraudulent claim for payment by a government entity. This includes false claims submitted to a Medicare, Medicaid or any other governmental program.

Stark Law (PHYSICIAN SELF-REFERRAL PROHIBITION)

A law that prohibits a physician from making a referral to an entity with which he/she or their immediate family has a financial relationship if the referral is for the furnishing of designated health services. The only exceptions made are those that are set forth in the statute or impending regulations.

FWA News

Office of Inspector General (OIG) Outlook 2013 Video Program

OIG senior executives discuss emerging trends in combating fraud, waste, and abuse in Federal health care programs, OIG's top priorities for 2013, and upcoming projects in the newly released OIG Work Plan. You can watch the entire half hour program at **http://go.usa.gov/YyKk**.
The entire program has also been broken down into the 4-to-6 minute videos on this webpage so you can watch them as your schedule permits at **http://go.usa.gov/YyK4**

OIG Fiscal Year 2013 Work Plan

On an annual basis, OIG publishes a Work Plan summarizing new and ongoing reviews that OIG plans to pursue with respect to U.S. Department of Health and Human Services (HHS) programs and operations during the fiscal year and beyond.

If you would like to read the Fiscal Year 2013 Work Plan, please visit the OIG website at **https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf**.

Examples of Fraud, Waste and Abuse

Member Fraud, Waste and Abuse Examples

- Doctor shopping to obtain multiple prescriptions
- Prescription stockpiling
- Using someone else's insurance card to obtain medical care
- Misrepresenting eligibility
- Filing claims for services or medications not received

Provider Fraud, Waste and Abuse Examples

- Billing for services not rendered
- Double billing for services that were provided
- Falsifying credentials
- Accepting kickbacks for referring patients
- Billing for a more costly service than the one actually performed (Upcoding)

Pharmacy Fraud, Waste and Abuse Examples

- Billing multiple payers for the same prescription
- True-Out-Of-Pocket (TrOOP) manipulation
- Billing for brand when a generic is dispensed
- Billing for prescriptions that are never picked up
- Dispensing expired or adulterated prescription drugs

Sales Agents Fraud, Waste and Abuse Examples

- Enrolling a beneficiary in a Medicare Plan without the beneficiary's knowledge or consent
- Offering a beneficiary a kickback as an inducement to enroll
- Misuse of Scope of Appointment form
- Using beneficiary information obtained through another agent, friend etc. to market Medicare plans
- Publishing or stating misleading information to encourage enrollment

Health Plan (Sponsor) Fraud, Waste and Abuse Examples

- Inappropriate enrollment
- inappropriate disenrollment
- Incorrect calculation of TrOOP
- Inaccurate eligibility information
- Inaccuracies in coordination of benefits

If you have any news or questions that you would like included in the newsletter, please send an email to:

HISCCOMPLIANCE @ BCBSIL.COM

For additional FWA information, please visit:

www.stopmedicarefraud.gov

HCSC and its subsidiaries are founded on the basic principles of good business behavior. Among these principles are a commitment to the highest standard of business ethics and integrity. This includes strict observance of and compliance with the laws and regulations governing the business operations of HCSC, and in particular, the services that it performs or has delegated to others to perform pursuant to its Medicare and Medicaid contract(s).

HCSC's toll free Medicare Fraud Hotline is available to allow employees or other individuals to seek guidance or report a matter of concern. The term "other individual" refers to subcontractors, agents and directors who are involved in the Medicare Part D and or Medicare Advantage benefit. All calls can be made anonymously and without fear of intimidation or retaliation. The calls are not traced and the information is treated in a confidential manner, subject to the limits imposed by law. This Medicare Fraud Hotline is available 24 hours a day, 7 days a week and is not staffed by employees of either HCSC or its subsidiaries.

Visit our website:

www.hisccompliance.com

Fraud Hotline: Available 24/7

Report fraud issues anonymously

1-800-543-0867 – for Members

1-877-272-9741 – for Producers, Vendors & Providers

1-877-211-2290—for Employees

Training Requirements

MEDICARE TRAINING

Employees, temporary agency employees, contractors, vocational technical workers whether paid or not who have been identified as being involved or working on the Medicare Part D contract are required to complete the following training assignments **within 90 days of hire** and **annually** thereafter:

- General Compliance Training - Includes Code of Conduct, compliance program, non-retaliation policy and resources available to report concerns
- Fraud, Waste and Abuse Training

For additional information please refer to the Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

MEDICAID TRAINING

Employees, temporary agency employees, contractors, vocational technical workers whether paid or not who have been identified as being involved or working on the State Covered Insurance (SCI) products are required to complete the following training assignments **within 90 days of hire and annually** thereafter:

- General Compliance Training - Includes Code of Conduct, compliance program, non-retaliation policy and resources available to report concerns
- State Specific Medicaid Deficit Reduction Act (DRA) Training– Includes both the Federal and State false claims act and a fraud, waste and abuse course