Compliance and Fraud, Waste and Abuse Training

Companion Benefit Alternatives, Inc.

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To navigate through this course you can:

- Scroll to each slide using the scroll bar on the right or your computer mouse.
- Use the navigational buttons at the top or bottom of each screen in the toolbar (depending on which version of Adobe Acrobat you have).
- When viewing the course full screen, click on each slide to proceed to the next.
Welcome to our **Compliance and Fraud, Waste and Abuse** course.

When you complete this course, you will:

- Understand Companion Benefit Alternatives’ (CBA) Code of Conduct and commitment to doing business with those who are equally committed to upholding CBA’s values and ethics.

- Understand how to comply with all applicable federal and state compliance and fraud, waste and abuse regulations.

- Be able to identify and report potential violations of the Code of Conduct and fraud, waste and abuse.
The Centers for Medicare & Medicaid Services (CMS) has mandated that Medicare Advantage (MA) and Prescription Drug Program (PDP) sponsors (like BlueCross® BlueShield® of South Carolina) are responsible for providing annual compliance training to First Tier, Downstream and Related Entities.

Section 1 – Definitions  
Section 2 – Compliance  
Section 3 – Fraud, Waste and Abuse  
Section 4 - Laws and Governing Agencies  
Section 5 – Reporting Violations

CBA has created this course to meet CMS’ training requirements. On behalf of BlueCross, CBA manages behavioral health and substance abuse benefits for Medicare Advantage members. CBA is a separate company.

At the conclusion of this training, an individual authorized to represent your organization must complete the online attestation form stating that all applicable individuals within your organization have completed the annual compliance training.

*** Complete training of current employees and submission of the attestation by March 31st of each year. Provide training to new employees within 30 days of hire date.***

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.
Section 1 Definitions

These definitions will help you understand and comply with CMS requirements:

- Code of Conduct
- First Tier Entity
- Downstream Entity
- Related Entity
- Fraud
- Waste
- Abuse
Section 1 Definitions

• **Code of Conduct** explains the organization’s commitment to ethical behavior by:
  1. Clearly articulating the organization’s commitment to comply with all applicable statutory and other regulatory requirements.
  2. Delineating the organization’s expectations of employees and contracting entities to act in an ethical and compliant manner.
  3. Specifying the consequences of failure to comply with the Code of Conduct.

• **First Tier Entity** refers to a party that enters into a written arrangement acceptable to CMS with a Sponsor to provide *administrative services or health care services* for Medicare beneficiaries under Medicare Advantage (MA) or Part D (PDP) plans. A First Tier Entity provides a service that the MA or PDP plan would otherwise be responsible to perform to meet requirements of their CMS contract.
Section 1 Definitions

- **Downstream Entity** refers to any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a Sponsor and a First Tier Entity.

- **Related Entity** is any entity that is related to the Sponsor by common ownership or control and either:
  - Performs some of the Sponsor’s management functions under contract or delegation
  - Furnishes services to Medicare enrollees
  - Leases real property or sells materials to the Sponsor at a cost of more than $2,500 per contract period (usually one year)
Section 1 Definitions

- **Fraud** – An intentional deception or misrepresentation that an individual or entity makes knowing that it could result in some unauthorized benefit to the individual, the entity or some other party. Four key elements of fraud are:
  1. Intent to defraud through deliberate deception
  2. Knowledge of wrongdoing
  3. Misrepresentation in making a false impression
  4. Reliance on receiving benefit to which the recipient is not legally entitled

- **Waste** – Using health care benefits or spending health care dollars without real need.

- **Abuse** – Activity that is not consistent with generally accepted business or medical standards or practices.
Section 2 Compliance

This section discusses the CBA Code of Conduct for ethical behavior and describes some laws related to compliance.

- CBA Code of Conduct
- Ethics and Integrity
- Conflict of Interest
CBA’s Code of Conduct sets expectations for our employees and those with whom we contract to understand and comply with all laws, regulations and policies concerning our business. We are committed to integrity, conducting ourselves in a legal and ethical manner, and doing business with health care professionals, entities, agents and vendors who are equally committed to adhering to our Code of Conduct.

To support our mutual commitment, all organizations (First Tier, Downstream and Related Entities) who provide services related to our Medicare Advantage plans must know and comply with our Code of Conduct. CMS requires that sponsors and their First Tier, Downstream and Related Entities have policies and procedures in place to ensure compliant and ethical conduct.
Section 2 Compliance

Companion Benefit Alternatives
Code of Conduct

• **Comply** with all CMS laws, regulations and guidance, and laws and regulations about privacy and security of protected health information.

• **Submit** truthful and accurate reports of required or requested data.

• **Conduct** business with integrity demonstrating ethical behavior.

• **Ensure** that employees and others who provide services related to Medicare Advantage receive effective training on compliance with the Code of Conduct, including consequences of non-compliance.

• **Cooperate** with government investigations.

• **Encourage** prompt reporting of suspected or actual violations of the Code of Conduct.

• **Monitor** and eliminate relationships that may result in conflicts of interest.

• **Adhere** to a non-retaliation policy.
Section 2 Compliance

Ethics and Integrity

**Ethics** refer to standards of morally good or bad, right or wrong conduct.

**Integrity** is the level to which one adheres to his or her ethical standards.

An organization’s ethical standard is called its Code of Conduct. In addition to personal ethical standards, CBA employees are required to adhere to our corporate Code of Conduct when carrying out their job responsibilities.

Some examples of ethical behavior are:

- Following all laws and regulations that apply to our business.
- Not engaging in any false or dishonest practices.
- Avoiding knowingly presenting as accurate any incorrect, incomplete, false or misleading information.
Section 2 Compliance

Conflict of Interest

Conflict of Interest refers to any situation in which an individual is in a position to exploit a professional or official capacity in some way for his or her personal or corporate benefit.

Employees should avoid outside jobs or activities that conflict with their current position or reflect poorly on the company.

Employees are required to complete a conflict of interest form annually or when their outside jobs or activities change.
Section 3 Fraud, Waste and Abuse

This section discusses how to detect, prevent and report fraud, waste and abuse. When you complete this section, you will:

- Review definitions for fraud, waste and abuse
- Understand how fraud, waste and abuse affects you, your employer and Medicare beneficiaries
- Review examples of fraud, waste and abuse
Section 3 Fraud, Waste and Abuse

- **Fraud** – An *intentional* deception or misrepresentation that an individual or entity makes knowing that it could result in some unauthorized benefit to the individual, the entity or some other party. Four key elements of fraud are:
  1. Intent to defraud through deliberate deception
  2. Knowledge of wrongdoing
  3. Misrepresentation in making a false impression
  4. Reliance on receiving benefit to which the recipient is not legally entitled

- **Waste** – Using health care benefits or spending health care dollars *without real need*

- **Abuse** – Activity that is *not* consistent with *generally accepted* business or medical standards or practices
Section 3 Fraud, Waste and Abuse

- **Fraud, Waste and Abuse Facts**
  - Annually, taxpayers pay more than $1 billion in fraudulently inflated drug prices representing 1/5 of Medicare spending in 2000. (Government Accounting Office, 2000)
  - The FBI secured 560 convictions for health care fraud in 2001, a four-fold increase from 1992. (FBI, 2001)

- **Effects of Fraud, Waste and Abuse**
  - Increased health care costs for everyone in order to pay for fraudulent claims.
  - Increased need for expenditures of federal, state and local tax funds.
  - Decreased services to beneficiaries due to added administrative requirements of audit and oversight.
Section 3 Fraud, Waste and Abuse

• Fraud Examples
  - A DME provider submits claims for equipment that was not delivered to the beneficiary or was not medically necessary.
  - A doctor provides a beneficiary with a service that is clearly not covered, but intentionally submits the claim with a procedure code for a covered service.

• Waste Examples
  - A physician consistently prescribes a highly priced, non-preferred drug when a less expensive preferred or generic drug is available and is effective.
  - An provider consistently submits claims with missing information resulting in increased costs to obtain information needed to complete processing.
  - A provider continues to file claims for a member after she is deceased, causing unnecessary administrative costs to process claims and to print and mail EOBs.

• Abuse Examples
  - A provider submits a claim for a comprehensive (one-hour) exam when the patient’s treatment required only 20 minutes.
  - An employee uses company email to receive orders for her personal business.
Section 4 Laws and Governing Agencies

• BlueCross BlueShield of South Carolina contracts with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare Advantage plans to beneficiaries.

• The BlueCross Medicare Advantage program is committed to complying with applicable state and federal laws, rules and regulations, including Medicare requirements.

• BlueCross requires the same commitment from its First Tier, Downstream and Related Entities who provide services to its Medicare Advantage members or support its Medicare Advantage program through administrative services that otherwise, would be required of the Plan.
Section 4 Laws and Governing Agencies

Privacy Act of 1974 and Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Created national standards to protect privacy and security of individuals’ personal information (PHI). To comply with HIPAA, your organization should have policies and procedures that:

- Define permitted use of PHI and other confidential information
- Secure electronic transmission of PHI
- Allow access to only minimum information necessary
- Require written agreements with contracting parties regarding security requirements and appropriate use of PHI
- Ensure timely training of new hires and annual training of existing staff on privacy, security and the organization’s Code of Conduct
Section 4 Laws and Governing Agencies

**False Claims Act** – Prohibits knowingly presenting to the federal government a false or fraudulent claim for payment or approval. It prohibits knowingly using a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents. It also protects individuals from retaliation for reporting suspected fraud and abuse.

**Anti-Kickback Statute** – Provides penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce or reward business payable under the Medicare or other federal health care programs.
Sarbanes Oxley Act of 2002 (SOX) – Creates corporate control environments and makes executives personally accountable for internal control over financial reporting. Even though SOX does not apply to companies that are not publicly traded, CBA is required to comply with the National Association of Insurance Commissioners (NAIC) Model Audit Rule (MAR), which is the private insurance industry’s version of SOX. Effective January 2010, CBA was and remains compliant with the requirements of MAR.
Section 4 Laws and Governing Agencies

A number of government agencies oversee compliance and fraud, waste and abuse related to Medicare Advantage and Prescription Drug programs. These agencies include:

- Office of Inspector General
- Defense Criminal Investigative Services
- Department of Justice
- Federal Bureau of Investigations
- United States Attorney’s Office

These agencies focus primarily on fraud and abuse by reviewing providers’ and beneficiaries’ claims to ensure there is no intentional misrepresentation of information. Reviews are done through investigations, audits and evaluations.

All employees of CBA and its Downstream Entities are responsible for identifying and preventing non-compliance and fraud, waste and abuse by immediately reporting any suspected or known violations.
Section 5 Reporting Violations

Reporting and Consequences

Reporting Violations

Question and/or challenge situations in which you suspect something improper, unethical or illegal is going on, and promptly report any suspected misconduct. Being aware of suspected misconduct and not reporting it could result in disciplinary action against you.

Consequences of Violations

Violation of any federal or state law or regulation, including failure to report known or suspected violations, can result in penalties, corrective action and other legal ramifications.

Employees who are aware of and fail to report suspected or known violations are subject to disciplinary action up to and including termination of employment.
Section 5 Reporting Violations

Investigation of Reported Violations

Investigations of Violations

• CBA will make every attempt to investigate issues reported through regular channels or anonymously, once they have been sufficiently substantiated. Be aware that if you do not provide enough information in your anonymous report, it may limit our ability to conduct an investigation.

• Even if you are not the person who reports the misconduct, you have an obligation to cooperate in the investigation of the matter.
CBA’s non-retaliation policy is one of the most important elements of our ethics and compliance program. Open communication of issues and concerns without any fear of retribution or retaliation is vital to the success of the Code of Conduct. Our company has a non-retaliation policy to protect individuals who report suspected misconduct.

CBA requires our Downstream Entities to adhere to a non-retaliation policy that provides protection of employees who report suspected or actual compliance violations.
Section 5 Reporting Violations

Here are the ways to report suspected violations of Medicare Advantage and Part D Prescription Drug compliance policy. Your information is confidential and you can remain anonymous.

Medicare Advantage or Part D Prescription Drug Compliance Concerns

Please report all compliance concerns, including issues regarding HIPAA Privacy and Security, to our Compliance Hotline or website:

Compliance Hotline: 1-888-263-2077
Compliance Website: www.WebReportingHotline.com
Section 5 Reporting Violations

**Fraud Hotline:** 1-800-763-0703
**Fax:** 803-264-4050
**Mail:** Anti-Fraud Unit
Mail Code AX-E01
P.O. Box 24011
Columbia, SC 29224-4011

**Office of Inspector General**
**Phone:** 1-800-HHS-TIPS (800-447-8477)
**Fax:** 1-800-223-2164
**Email:** [HHSTips@oig.hhs.gov](mailto:HHSTips@oig.hhs.gov)
**Mail:** Office of the Inspector General
HHS TIPS Hotline
PO Box 23489 S
Washington, DC 20026

**Medicare Drug Integrity Contractor (MEDIC) Health Integrity, LLC**
**Phone:** 1-877-7SafeRx (1-877-772-3379)
**Fax:** 410-819-8698
**Website:** [www.healthintegrity.org](http://www.healthintegrity.org)
Congratulations!

You have completed the Compliance training course for providers and other entities who contract with Companion Benefit Alternatives.

Last Step for Completion … Important!

All trainees must sign the Training Log. Keep the training log for 10 years to comply with CMS document retention laws in the event of an audit.

An authorized representative of the company must complete the Attestation Form verifying that all applicable individuals within the organization have taken this course. Submit the Attestation Form to Companion Benefit Alternatives by March 31, 2012, to confirm that your organization has met this mandatory annual requirement.

Submit your online attestation now:
https://www.surveymonkey.com/s/CBA2012AnnualAttestation

Or
Put “Annual Attestation” and your company name in the subject line and email your attestation to:
CBA.ProvRep@companioniogroup.com
Sample Compliance Training Log

By signing below, I acknowledge that I have read and understand the Companion Benefit Alternatives Compliance Training document.

<table>
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<tr>
<th>Printed Name</th>
<th>Signature</th>
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Business Name: __________________________________________________________
Tax Identification Number: ________________________________________________
NPI (if health care provider): __________________________________________
Companion Benefit Alternatives
Medicare Advantage and Prescription Drug Compliance Sample Attestation

Entity’s Name:______________________________________________
As an authorized representative of _______________________________, (Entity) I attest to the following:
[  ] I attest that all Medicare Advantage activities delegated to Entity by CBA are fully compliant with all CMS guidance, HPMS memos and other reference materials.
[  ] I attest that staff of Entity and each applicable Downstream Entity that has any responsibilities or access to information related to BlueCross’ Medicare Advantage delegated activities fully meet compliance as required by CMS guidance, HPMS memos and other reference materials, including, but not limited to, training on Code of Conduct and Fraud, Waste and Abuse, completing Conflict of Interest attestation, and passing Office of Inspector General (OIG) exclusion list screening.
[  ] I attest that Entity will remain in compliance with all CMS guidance, HPMS memos and other reference materials during the term of the Agreement with CBA, or will immediately notify CBA of any non-compliant situation or activity.
[  ] I agree to maintain and make available as stated in the Agreement between Entity and BlueCross or otherwise upon request, reports, policy and procedure documents, training logs, results of OIG screenings, copies of Conflict of Interest attestations, and other records to verify and substantiate the information under this attestation for at least a period of 10 years following the end of the Agreement.

Signature:_________________________________________
Title:_____________________________________________
Date:_____________________________________________

*** Complete training of current employees and submit the attestation by March 31st of each year. Provide training to new employees within 30 days of hire date***