Welcome!

Fraud, Waste and Abuse Training with Highmark

The program will begin at noon.

You will hear silence until we begin.

Please take this opportunity to check your connections.

The Q&A box is available to type any questions or issues.

Provider Fraud, Waste and Abuse Training

June 30, 2026

Learning Objectives

1. Provide an overview of Fraud, Waste and Abuse (“FWA”)
2. Review Fraud, Waste and Abuse Laws and Regulations
3. Identify provider responsibilities as they relate to Fraud, Waste and Abuse
4. Discuss provider documentation requirements
5. Identify the various types of Fraud, Waste and Abuse Investigations
6. Discuss outcomes for non-compliance with State, Federal and contractual obligations

Disclaimer

The information provided in this presentation outlines the requirements for claims billing audits completed by Highmark's Financial Investigations and Provider Review ("FIPR") Team.

Providers may also be required to complete other audits by Highmark or State and Federal oversight agencies as a requirement of their participation in Federal and State healthcare programs.

Please consult your provider manual and the appropriate Federal and State regulatory agency websites for further information.

Today’s Speakers

Financial Investigations Provider Review (“FIPR”)

Mara Elliott, MBA, RHIA, *Senior Business Solutions Consultant*

Kylie Wilson, MS, *Business Analyst Consultant*

Agenda

- Overview of FWA
- Laws and Regulations
- Provider Responsibilities
- Documentation Requirements
- Types of Investigations
- Outcomes for Noncompliance
- Resources and Websites

Overview of FWA

Definitions of FWA

Fraud

- Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare 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 healthcare benefit program.
- Fraud is intentional or actions that result in deliberate overpayments.

Waste

- Practices that, directly or indirectly, result in unnecessary costs to the Medicaid and Medicare Programs, such as overusing services.
- Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse

- Actions that may, directly or indirectly, result in unnecessary costs to the Medicaid and Medicare Programs.
- Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of FWA

Fraud

- Billing for services not provided (known as phantom billing)
- Upcoding (billing for a more expensive service than received
- Unbundling (multiple bills for same service
- Misrepresenting services (billing medically unnecessary services)
- Falsifying records (such as diagnosis)
- Kickbacks (paying/receiving money in exchange for business)

Waste

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory

Abuse

- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

FIPR Mission and Strategy

- **Financial Investigations and Provider Review ("FIPR")** supports Highmark by investigating fraud, waste and abuse ("FWA") and recovering overpayments for our customers.
- FIPR reviews and investigates potentially fraudulent and/or inappropriate billings submitted by providers and/or participants, using industry-leading data analytics and national vendors.
- FIPR also works with local, state and federal law enforcement agencies to identify and remove unscrupulous providers from our network.

Highmark Mission:
Medicaid that goes beyond care and D-SNP coverage that helps you spend less.

FIPR Mission:
To protect our customers and lower the cost of healthcare by deploying comprehensive solutions that combat FWA

FIPR Strategy:
Utilize data analysis techniques to identify aberrant claims, perform claim coding reviews and conduct a variety of audits using investigative methods to assess the appropriateness of provider payments and pursue overpayment recoveries

FIPR Team and Functional Areas

A multi-faceted team that is responsible for detecting and investigating FWA.

Special Investigations

- The Special Investigations Unit ("SIU") is responsible to prevent, detect and investigate FWA.
- The SIU is comprised of CFEs, Investigators, and a Coordinator.
- The SIU is charged with:
  - Auditing and investigating providers
  - Communicating audit results and coordinating recoveries
  - Collaborating with law enforcement and government agencies

Ideation & Coding Review

- The Ideation and Coding Review team is responsible for receiving, assessing and progressing FWA referrals.
- The team is comprised of Medical Coders and Investigators.
- The team is charged with:
  - Triaging FWA calls and emails
  - Data-mining potential FWA leads
  - Reviewing medical records

Vendor and FWA Solutions

- The Vendor and FWA Solutions team is responsible for auditing and monitoring of improper payments.
- The team is comprised of delegated payment integrity vendors, AHFIs, Fraud Analysts, and Investigators.
- The team is charged with:
  - Managing vendors
  - Conducting pre-payment reviews
  - Conducting post-payment reviews

Compliance & Reporting

- The FIPR Team is responsible for ensuring compliance standards and accurate financial reporting.
- The team is comprised of Business Analyst Consultants.
- The FIPR Team is charged with:
  - Reporting financial data
  - Implementing an effective FWA program

FIPR Functions

What we DO and why

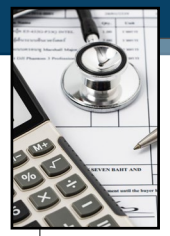
- Prevent, detect and investigate alleged FWA referrals
- Identify and recoup inappropriate payments
- Responsibility to educate providers on what is required
- Work with Federal, State and Local law enforcement agencies
- Believe in maintaining the integrity of services provided to members
- To ensure services are sustainable in the future

What we DON'T do

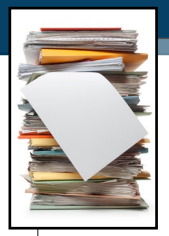
- Criminal investigations (Local, State, Federal law enforcement)
- Complaints or grievances
- Approve documentation templates
- Investigate provider related HIPAA concerns or quality of care concerns
- Review medical necessity
- Licensing

Red flags are patterns, practices or aberrant activities that indicate the possibility of fraud. Through identifying and reporting these activities, **YOU** can help combat FWA.

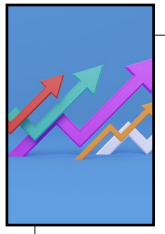
Examples of Red Flags



Billing for services that haven't been rendered

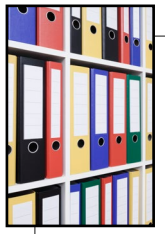


Unusual/inconsistent billing practices



Unusually high volume or percentage of the same services

High dollar member reimbursement claims



Altering receipts or claims

Pressure to pay claims quickly

Submitting multiple billings for the same service

Laws and Regulations

False Claims Act

Key Provisions

- Federal law that imposes liability on persons and companies who defraud government programs.
- Under the FCA, it is illegal to submit false or fraudulent claims for payment to Medicare or Medicaid.
- Qui tam provision – allows individuals who are not affiliated with the government to file actions on behalf of the government in exchange for a percentage of any recovery.

Penalties

- Fines between $5,000 - $10,000 per claim
- Additional monetary penalties up to 3x the amount of damages
- Federal and state exclusions

Impact

- Saad Enterprises Inc., dba Saad Healthcare, agreed to paid $3M to resolve allegations that it violated the False Claims Act by knowingly submitting false claims for the care of hospice patients who were ineligible for the Medicare hospice benefit as they were not terminally ill.
- *Qui tam* lawsuit was filed by Melissa Wolff and Whitney Sims, former Saad employees.

For more information, refer to 31 United States Code (USC) Sections 3729–3733

Anti-Kickback Statute

Key Provisions

- Federal law that prohibits financial payments or incentives for referring patients or generating federal healthcare business.
- Under the Anti-Kickback Statute, it is illegal to knowingly and willfully solicit, receive, offer or pay any kickback, bribe or rebate for referrals for services that are paid under a federal healthcare program. Kickbacks can be anything of value – not just cash.
- Covers both those that offer and receive kickbacks.

Penalties

- Violation of the Anti-Kickback Statute is a felony and upon conviction, individuals can be fined up to $100,000 or imprisoned up to 10 years, or both.

Impact

- Patrick Moore agreed to pay over $7.2M in restitution for his role in a scheme to pay and receive illegal kickbacks in exchange for inducing Medicare beneficiaries to accept medically unnecessary genetic tests.
- Moore received approximately $4.3M in kickbacks and bribes from his co-conspirators in exchange for the referral of beneficiary insurance information, DNA specimens and accompanying doctors' orders for genetic testing.

See 42 United States Code § 1320a-7b for further information

Stark Law

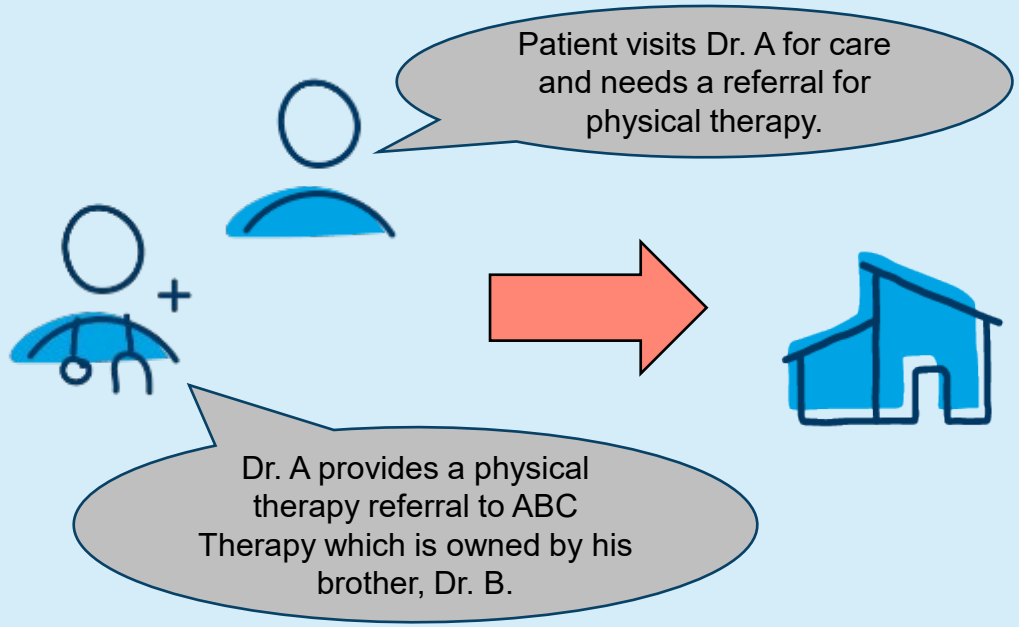
Law that prohibits physicians from referring patients to receive designated health services payable by Medicare or Medicaid from entities with which the physician (or a member of his or her family) has a financial relationship.

Under the Stark Law, financial relationships can include both ownership/investment interests and compensation arrangements. However, exceptions may apply.

- Claims that do not comply with the Stark Law are **not payable.**

Violations of Stark Law can include the following penalties:

- Refund of monies received by physicians and facilities for amounts collected
- Up to $15,000 penalty payment for each service provided
- Exclusion from the Medicare and Medicaid programs
- Up to $100,000 penalty payment for each attempted scheme



EXAMPLE

Gulfcoast Eye Care agreed to pay $615k to resolve allegations of violating the Stark Law and FCA. The practice maintained a financial arrangement with a third-party provider that incentivized physicians to refer patients for diagnostic procedures. Physicians received financial benefits tied to the volume of procedures ordered, which were then billed to Medicare and Medicaid.

See 42 United States Code § 1395nn for further information

Laws and Regulations

Deficit Reduction Act ("DRA")

The DRA established the Medicaid Integrity Program, the first comprehensive Federal strategy to reduce FWA in the Medicaid Program.

The DRA established anti-fraud provisions, such as:

- Strengthening the ability of State Medicaid agencies to pursue third party liability;
- Establishing a national expansion of the Medicare-Medicaid data match program; and
- Including incentives for states to enact their own False Claims Act statutes.

See Public Law 109-171 for further information

Balanced Budget Act ("BBA")

The BBA expanded the OIG's sanction authorities and established a toll-free FWA hotline for individuals who suspect that FWA has occurred in Federal Healthcare Programs.

The BBA required health plans to implement the following measures:

- Document policies and procedures
- Articulate a commitment to comply with State and Federal regulations
- Designate a Compliance Officer and Compliance Committee
- Develop a solid detection and reporting processes
- Provide education to employees, providers and members

See Public Law 105-33 for further information

Laws and Regulations

Affordable Care Act ("ACA")

The ACA's primary goal was to establish affordable health insurance available to more people and expand the Medicaid Program.

The ACA enacted provisions, targeted toward the prevention of FWA, including the following:

- Establishment of screening requirements for providers and suppliers;
- Expansion of the role of Recovery Audit Contractors;
- Requirement of providers to develop Compliance Plan
- Revisions to the FCA and Stark Law
- New fines and penalties for providers who fail to return overpayments within 60 days

See Public Law 111-148 for further information

Civil Monetary Penalties Law

Law that allows Office of Inspector General ("OIG") ability to seek civil monetary penalties for a wide variety of abusive conduct.

Reasons the OIG may impose civil penalties includes, but is not limited to:

- Submitting claims for items or services not provided
- Making false claims
- Arranging for services or items from an excluded individual or entity
- Presenting claim patterns for medically unnecessary services or items
- Knowing of and failing to report and return an overpayment
- Failing to grant OIG timely access to records

For more information, refer to 42 USC 1320a-7a and the Act, Section 1128A(a).

Other Laws and Regulations

Health Insurance Portability and Accountability Act	The Health Insurance Portability and Accountability Act (“HIPAA”) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient’s consent or knowledge. *See* Public Law 104-191 *for further information.*
Fraud Enforcement and Recovery Act of 2009	The Fraud Enforcement and Recovery Act of 2009 (“FERA”) restates part of the False Claims Act to reflect the original intent of the law, including, but not limited to, broadening the range of conduct that can be subject to false claims prosecution, as well as updates to FCA filing procedures. *See* Public Law 111-21 *for further information.*
21st Century Cures Act	The 21st Century Cures Act enacted changes to strengthen fraud and abuse measures in the Medicaid program; including requiring states to screen and enroll providers with the State Medicaid Agency and establishing a timeline for states to adopt electronic verification systems. *See* Public Law 114-255 *for further information.*
Criminal HealthCare Fraud: Penalties	Persons who knowingly make a false claim may be subject to criminal fines up to $250,000 and imprisonment for up to 20 years. If the violations resulted in death, the individual may be imprisoned for any term of years up to life. *For more information, refer to 18 United States Code §1347.*

Beware of Scams

As Providers, it is your obligation to report anything suspicious. This means being on the look out for scams and **REPORT** anything that could be potential FWA.

This can include, but is not limited to:

- Member eligibility issues
- Relationships with healthcare agents and brokers
- Providing personal or financial information to someone claiming to work for Medicaid or Medicare and becoming threatening when information is not promptly provided
- Sham websites
- Use of artificial intelligence

If you suspect FWA, call us at 1-844-718-6400 so we may investigate your concerns. You can also use the online form to report suspected FWA.

Provider Responsibilities

Provider Compliance Plan

Providers are required to establish a compliance program that prevents and detects FWA as a condition of enrollment in the Medicaid and Medicare programs.

- All providers are required to have a compliance plan, no matter the size of your practice.

OIG Recommendations for Effective Compliance Program

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a Compliance Officer
4. Conduct appropriate training and education
5. Respond to detected offenses and develop corrective actions
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines
8. Compliance programs **MUST** be effective

Provider Screenings: WV Medicaid Requirements

WV Department of Health and Human Resources, Bureau for Medical Services (“BMS”) is required under the Affordable Care Act (“ACA”) and related regulations at 42 CFR 455 to follow specific provider enrollment and screening practices for WV Medicaid. BMS follows the policy manuals found on the BMS website, specifically Chapter 300, Provider Participation Requirements. Providers may enroll as inpatient or outpatient facilities, agencies, pharmacies, suppliers, individual practitioners or groups. All group practices must comply with WV law applicable to group and corporate practice.

- **Providers are responsible to screen all individuals, employees, contractors, owners, board of directors, etc. to assure that no entity or individual meets the federal or state criteria for exclusion.**

Below are links to the exclusion databases:

- **Federal Department of Health and Human Services, Office of Inspector General – List of Excluded Individuals and Entities:**
  - https://exclusions.oig.hhs.gov/
- **Federal General Services Administration, System for Award Management:**
  - https://sam.gov/content/home
- **West Virginia Medicaid Management Information System:**
  - https://www.wvmmis.com/default.aspx

Provider Screenings

Per provider contracts, Highmark requires providers to conduct employee sanction checks, complete all credentialing requirements, review exclusions and conduct criminal background checks of all practitioners and clinicians.

- Additionally, the following verifications are required:

A current, unrestricted license

Fully completed and attested CAQH application

NPI number

Resume/CV with work history to include month and year

Copy of current, unencumbered DEA certificate

Current hospital admitting privileges for PCP

Malpractice history as subject to decision by Highmark

Practitioners must maintain professional liability coverage

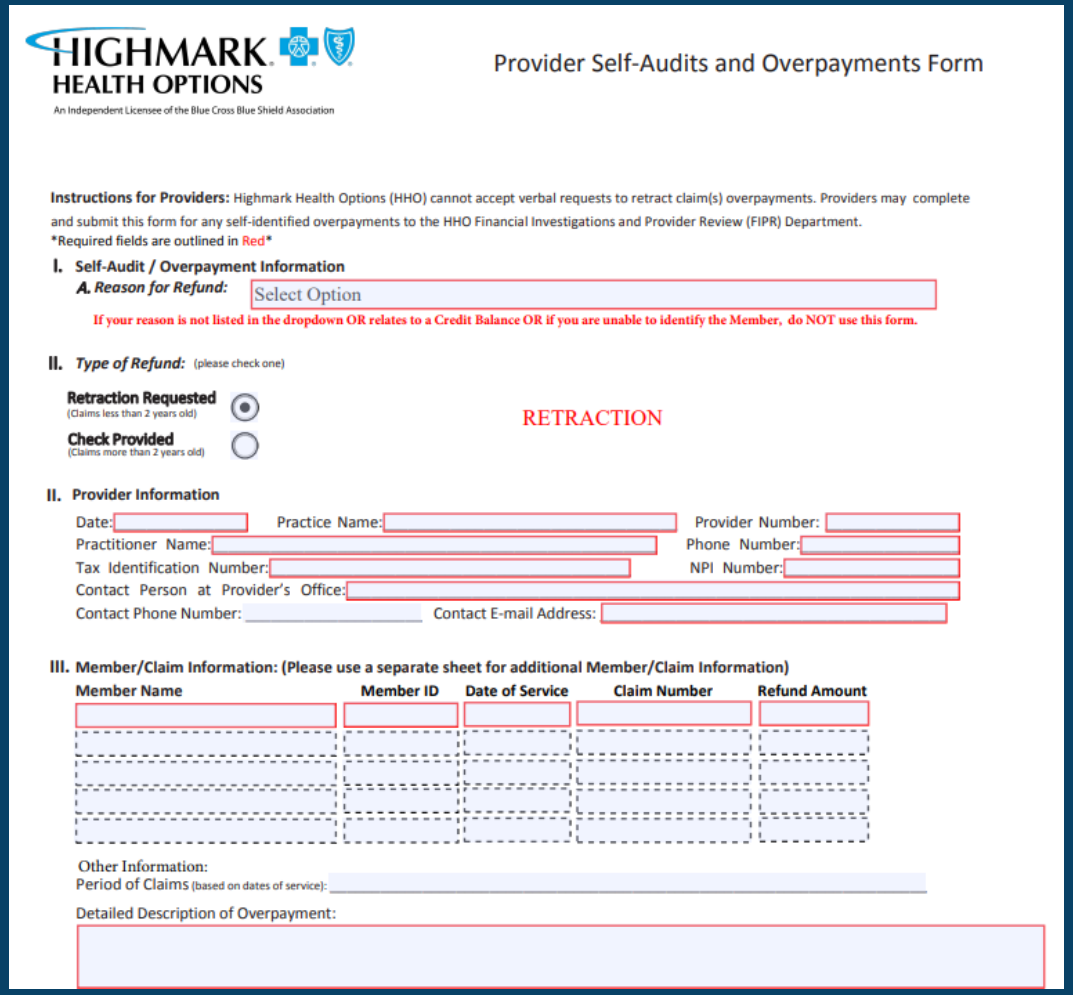
Active enrollment and participation in WV Medicaid programs

ECFMG certificate, if applicable

Provider Self-Audits: Required by OIG

- Providers can submit overpayments to Highmark by using the Provider Self-Audit Overpayment form found on our website
- Highmark relies on the Office of Inspector General ("OIG") self-disclosure requirements including sample sizes, reporting requirements and timeframes.
- Federal and state laws and regulations require overpayments to be returned within ***60 days*** of identification

Resources for Self-Audits:
OIG Guidance



HIGHMARK HEALTH OPTIONS
An Independent Licensee of the Blue Cross Blue Shield Association

Provider Self-Audits and Overpayments Form

Instructions for Providers: Highmark Health Options (HHO) cannot accept verbal requests to retract claim(s) overpayments. Providers may complete and submit this form for any self-identified overpayments to the HHO Financial Investigations and Provider Review (FIPR) Department.
Required fields are outlined in Red

I. Self-Audit / Overpayment Information

A. Reason for Refund: Select Option

If your reason is not listed in the dropdown OR relates to a Credit Balance OR if you are unable to identify the Member, do NOT use this form.

II. *Type of Refund:* (please check one)

Retraction Requested (Claims less than 2 years old) ◉ — RETRACTION

Check Provided (Claims more than 2 years old) ○

II. Provider Information

Date: Practice Name: Provider Number:
Practitioner Name: Phone Number:
Tax Identification Number: NPI Number:
Contact Person at Provider's Office:
Contact Phone Number: Contact E-mail Address:

III. Member/Claim Information: (Please use a separate sheet for additional Member/Claim Information)

Member Name	Member ID	Date of Service	Claim Number	Refund Amount

Other Information:
Period of Claims (based on dates of service):
Detailed Description of Overpayment:

Online Referral Form: Medicaid and D-SNP

Mail checks with a copy of this form to:

Highmark Health Options/Duals
Attn: FIPR
PO Box 890387
Camp Hill, PA 17089

For Claim Retraction **ONLY**, mail this form to:

Delivery Code: FIPR
Attn: FWA/SIU Unit
Highmark Health Options/Duals
120 Fifth Ave.
PAP-4
Pittsburgh, PA 15222

Email: ProviderSelfAudits@highmark.com

For more information on Provider Self-Audits, check out these resources:

- Provider Self-Audits
- Medicare Provider Manual
- Medicaid Provider Manual

Trend Process

- Providers can now electronically submit overpayments via TRENDSubmit.
- Secure, online process that allows providers to be notified of claim retractions in real-time.
- TRENDSubmit team provides user training resources and ongoing support.
- Contact Jennifer Baron to initiate access.

Medical Necessity: WV Medicaid

BMS Mission Statement

- *The Bureau for Medical Services is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that **assures access to appropriate, medically necessary and quality healthcare services for all members**; provide these services in a user-friendly manner to providers and members alike; and focus on the future by providing preventive care programs.*

Member Liability

- *Medicaid patients MUST PAY for:*
  - After Medicaid benefit is exhausted
  - **Not medically necessary**
  - Not approved by the Managed Care provider (except for medical emergency)
  - Convenience items not related to the medical care
  - Services provided when a patient is not eligible
  - Services from a provider who tells a patient that he/she will not bill Medicaid before the services is provided
  - Services provided when the patient refuses to use other private insurance
  - Services provided when the patient does not follow the plan provisions of their primary insurance
- *Medicaid members must not be billed or otherwise held responsible for claims denied for provider error.*

Medical Necessity: CMS Guidance

The CMS definition of medically necessary specifically states that a service must be medically necessary to be covered, which means that it must be reasonable and necessary for the purpose of diagnosing or treating illness or injury to improve the functioning of a malformed body member.

- Medically necessary refers to services or supplies that:
  - Are proper and needed for the diagnosis or treatment of the member's medical condition;
  - Are used for the diagnosis, direct care and treatment of the member's medical condition;
  - Meet the standards of good medical practice in the local community; and
  - Are not mainly for the convenience of the member or the doctor.
- These requirements are also included in the 2026 Highmark Health Options Duals (HMO SNP) Provider Manual.

Standards of Practice: Record Requirements

Payment will not be made when the review of a practitioner's medical records reveals instances where these standards have not been met.

Providers must maintain records in accordance with Federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. DHHS. Minimum documentations standards include:

- Conformance to federal and West Virginia Medicaid rules and regulations.
- Medical necessity and appropriateness.
- Payment to an enrolled and qualified provider on behalf of an enrolled member.
- Units and services billed match units and services documented in the providers' records.

Corrective Action Plans (“CAPs”)

The FIPR Team may recommend a CAP for providers.

- An investigation of a provider for aberrant behavior that results in overpayments may require a CAP. There may be other circumstances in which a CAP is needed, such as actions that may cause potential harm to patients, quality of care issues and inappropriate behaviors.
- The Investigator will consult with Highmark FIPR Management to determine if a CAP is needed. Other internal departments may be requested to provide feedback on corrective actions for a provider or member if additional opinions are needed to bring resolution to a case.

CAP Elements	1. Date
	2. Findings
	3. Timeframe of CAP
	4. Type of Actions
	5. Duration of CAP

If at any time the provider fails to fulfill the requirements of their CAP, the Investigator will discuss next steps with Highmark FIPR Management.

Medical Record Requests

The FIPR Team will conduct retrospective reviews of claims and medical records to ensure claims accuracy and documentation standards.

- Providers must provide requested records at no cost to Highmark. This includes notifying any third-party vendor who may maintain medical records of this stipulation.
- All requested documentation must be submitted at the time of the medical record request within 30 days from the letter date.

Documentation Requirements

Minimum Documentation: Provider Manual

Highmark requires providers to have medical records that comply with CMS, AMA, NCCI, NCQA, HIPAA Transactions and Code Sets, Medicaid regulations and Medicare manuals as well as other applicable professional associations and advisory agencies Providers should follow these guidelines for basic medical records.

- Providers are responsible for following all requirements under Federal and State regulations, publications and bulletins that are pertinent to the treatment and services provided.
- Providers should follow the medical record standards as defined in Medicaid contracts, Medicare manuals, provider contracts, provider manuals and all regulations.
- Providers must have member records that include all Medicaid and/or Medicare requirements, are individual and kept secure.
- Providers are responsible for obtaining the appropriate order, referral or recommendation for service.
- All documentation must meet the requirements of the service codes that are submitted on the claims form.
- All progress notes and billing forms must be completed after the session.
- All documentation and medical record requirements must be legible.
- All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
- All requirements for documentation must be completed prior to the claim form submission date.

Minimum Documentation: Provider Manual

Additionally, the medical records must have the following:

- Medical history, such as family history, psychosocial history, medical-surgical history, baseline physicals and periodic updates
- High risk behaviors (Tobacco/cigarette, alcohol, substance abuse, HIV/STD, nutrition, social and emotional risks, etc.,)
- Continuity of care is documented
- Immunizations and dates
- Must be easy to read and legible
- Must contain the minimum personal biographical data: DOB, Gender, Address, Home Telephone Number, Employer, Occupation, Work Telephone Number, Marital Status, Name of Next of Kin, Next of Kin Telephone Number
- Allergies and Adverse Reactions
- Significant illnesses and medical conditions
- Laboratory and other studies ordered

See “FWA Medical Records Request” within the Provider Manual for a complete list

Minimum Documentation: CMS – Documentation Matters Toolkit

- Providers are responsible for documenting each patient encounter completely, accurately and on time.
- Because providers rely on documentation to communicate important patient information, incomplete and inaccurate documentation can result in unintended and even dangerous patient outcomes.
- Accurate documentation supports compliance with federal and state laws and reduces fraud, waste and abuse.

CMS Resources

Documentation Matters Fact Sheet for Medical Professionals:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-medicalprof-factsheet.pdf

Documentation Matters Fact Sheet for Behavioral Health Practitioners:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf

Documentation Matters Fact Sheet for Medical Office Staff:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-officestaff-factsheet.pdf

Medical Records Resource Guide:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-recorddoc-resourceguide.pdf

Electronic Health Records Fact Sheet:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

Consent to Treatment

Federal Reference

AMA Code of Medical Ethics – Informed consent to medical treatment is fundamental in both ethics and law. The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention.

42 CFR 2.31 – Consent requirements

- (a) Required elements for written consent. A written consent to a use or disclosure under the regulations in this part may be paper or electronic and must include:
  - The name of the patient
  - The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure
  - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion
- (5) A description of each purpose of the requested use or disclosure.
  - The statement "at the request of the patient" is a sufficient description of the purpose when a patient initiates the consent and does not, or elects not to, provide a statement of the purpose.
  - The statement, "for treatment, payment and healthcare operations" is a sufficient description of the purpose when a patient provides a consent once for all such future uses or disclosures for those purposes

Consent to Treatment Guidance – Provider Manuals

- Valid for dates of service (update yearly)
- Identifies the patient
- Signed and dated by the patient
- Signed, dated and credentialed by the clinician
- List types of services and/or treatments
- Includes the benefits and potential risks
- Includes alternative services and/or treatments
- Must be easy to read and legible

These requirements are included in the 2025 Medicaid and 2026 D-SNP Provider Manuals

HIPAA and Privacy Practices

- HIPAA created greater access to healthcare insurance, strengthened the protection of privacy of healthcare data and promoted standardization and efficiency in the healthcare industry.
- HIPAA safeguards deter unauthorized access to protected healthcare information. As an individual with access to protected healthcare information, you must comply with HIPAA.
- The Privacy Rule of the Health Insurance Portability and Accountability Act ("HIPAA") requires covered entities to distribute a notice of their privacy practices to patients with respect to their protected health information.
    - Information regarding uses and disclosures of PHI
    - Patient's individual rights
    - Provider's duties
    - Complaints
    - Contact Information
- Privacy Practices are outlined in the Provider Manual to include the following:
    - Valid for dates of service
    - Identifies the patient
    - Signed and dated by the patient
    - Signed, dated and credentialed by the author/clinician
    - Must be easy to read and legible

For more information, see 45 CFR § 164.520

Damages and Penalties

Violations may result in civil monetary penalties. In some cases, criminal penalties may apply.

Progress Notes

- Dates of service
- Identifies the patient
- Signed, dated and credentialed by author/clinician
- Start and stop times for time-based services
- Units of service
- Place of service

Medication List

- Medication prescribed
- Signed and dated by clinician
- Lists dosages, dates and refills
- References the side effects and symptoms
- Must be easy to read and legible

Treatment Plan

- Identifies the diagnosis
- Identifies interventions and goals of treatment
- Document necessity for treatment
- Reviews are completed timely as applicable
- Must be easy to read and legible
- Valid for dates of service
- Identifies the patient
- Signed and dated by clinician (witness or author's identification)
- Documents that member or guardian reviewed or participated with the development of the treatment plan

These requirements are outlined in the 2025 Medicaid and 2026 D-SNP Provider Manuals

Types of Investigations

Types of FWA Activities

- The FIPR Team works to ensure that claims are paid correctly by both monitoring and auditing methods and in accordance with recipient benefits and provider contracts.

Routine Investigations

Investigation of a reported allegation related to organizational activities for potential fraud, waste and abuse.

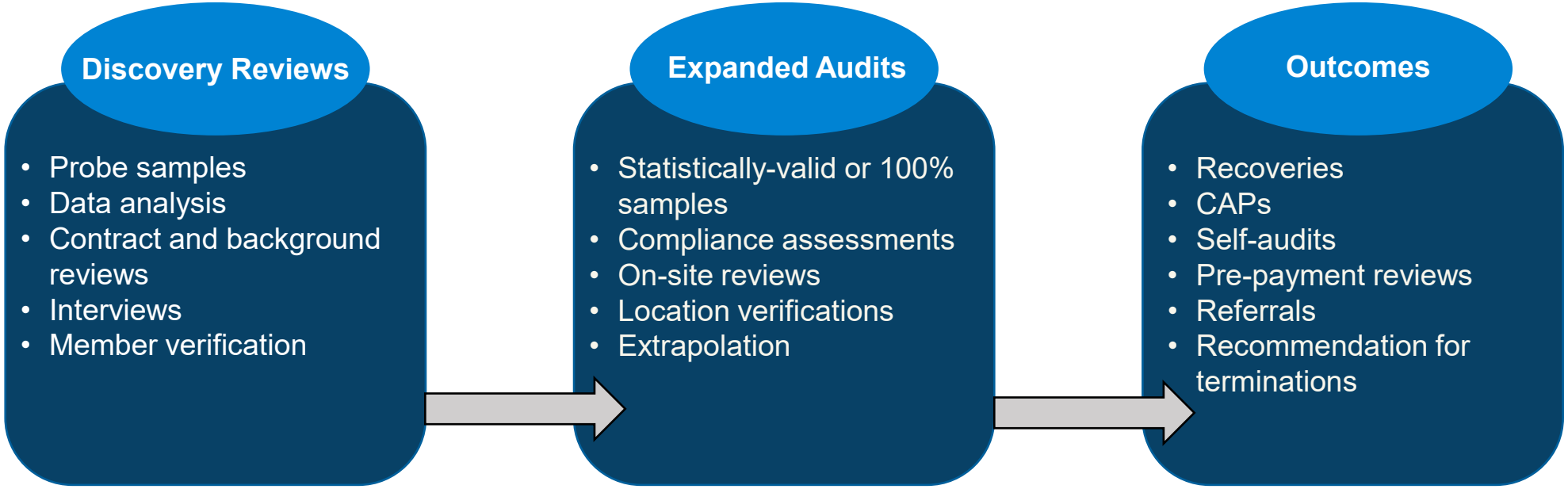
- Conduct Data Analysis
- Review Contract/ Provider Credentialing
- Review Internal Policy for Coding
- Review State/Federal Guidelines
- Member and Provider Interviews

Routine Investigations

- Coordinate with Other Departments
- Overpayment Notification
- Recoupment of Overpaid Dollars
- Submit State and CMS Referrals
- Local, State and Federal Collaboration

Routine Audits

- The Special Investigations Unit (“SIU”) performs provider profile and outlier analyses and conducts routine audits based on the Progressive Audit Protocol.
- The **Progressive Audit Protocol** is a comprehensive audit that includes discovery reviews, full sample reviews and provider CAPs.
- The SIU plans to make referrals of credible allegations of fraud in accordance with contractual and regulatory requirements.



Other SIU Activities

Recurring Overpayment Projects

- SIU conducts data analysis to monitor claims billing on a reoccurring basis (monthly, quarterly or yearly) to identify aberrant claim payments made. Overpayments can occur from the inability to systematically correct an issue, claim adjudication error and provider submission errors.
- **Examples Include:**
  - Surgical and Oxygen Unbundling
  - Member Eligibility
  - Services billed while on Hospice

Requests for Information (RFIs)

- RFI's are incoming requests sent by regulatory or law enforcement agencies to Managed Care Organizations (MCOs) like Highmark. These requests require MCOs to pull specific information including, but not limited to, claims data, contracts etc.
- **Sources include:**
  - BMS
  - CMS
  - I-MEDIC
  - OIG HHS
  - Attorney General and MFCU
  - FBI

Provider Education and Training

- The FIPR Team assures that its beneficiary and provider populations are also educated on healthcare FWA issues.
- **Methods of educating include:**
  - Fraud and Abuse Webpage
  - Provider and Member Newsletters
  - Audit Finding Notifications, including CAPs
  - Explanation of Benefits Statements
  - Provider and Member Forums
  - Provider and Member Manuals

FWA Solutions: Vendor

Pre-payment Edits and Reviews

- FIPR contracts with Vendors to monitor claims prior to payment to ensure claims accuracy. FIPR has the capability to suspend claims to conduct pre-payment reviews prior to releasing payment to flagged Providers.

Post-payment Audits

- FIPR contracts with Vendors to audit claims through retrospective reviews.

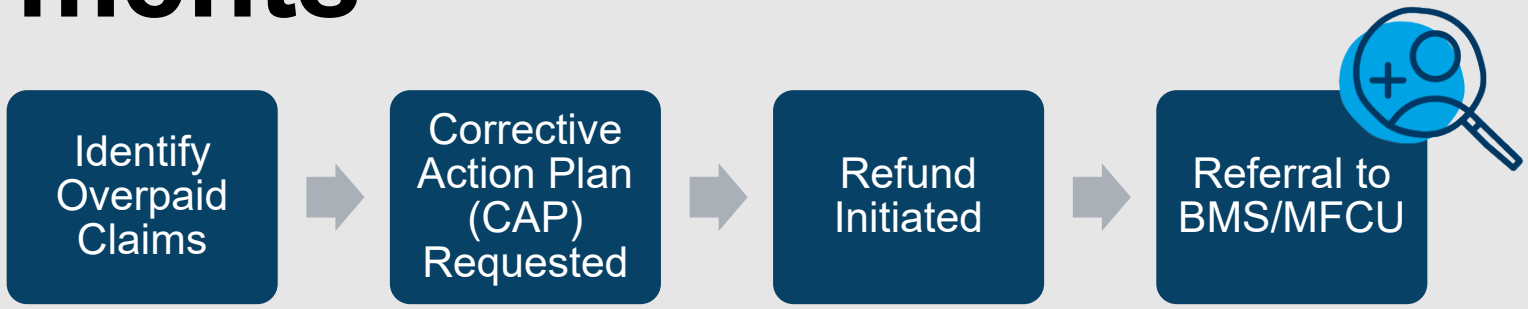
Other contracted vendors specialize in the following oversight activities that may include:

- Ensuring payment accuracy
- Inpatient/Outpatient Chart Reviews
- Clinical Validation
- Complex system edit set-ups
- Data mining trending healthcare patterns
- Contract Compliance

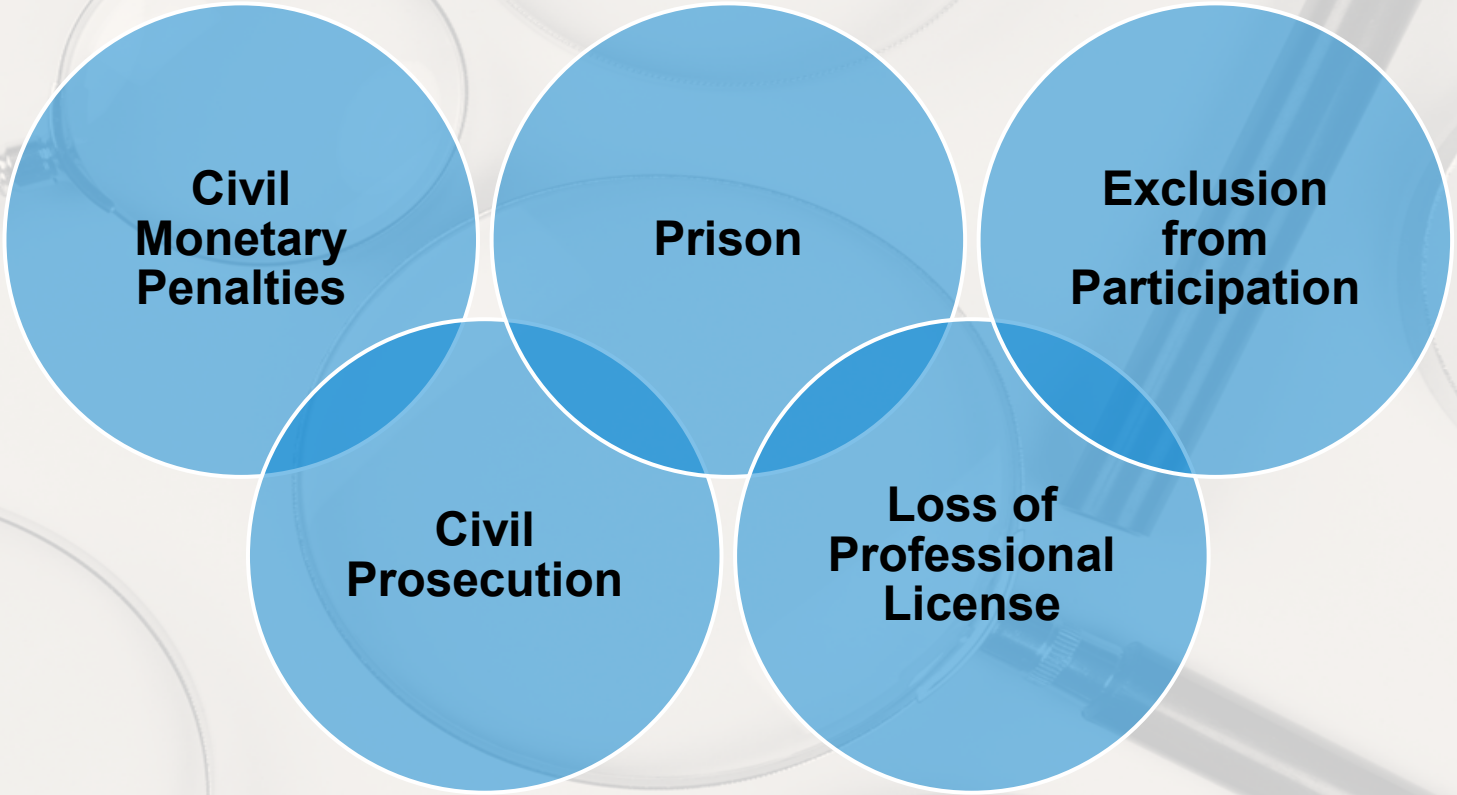
Cotiviti, CGI, Change Health, Trend and Performant are separate companies that administer pre-pay claim editing, retrospective data mining activities, FWA data-mining, readmissions, chart reviews, post-payment accuracy and integrity solutions.

Outcomes for Noncompliance

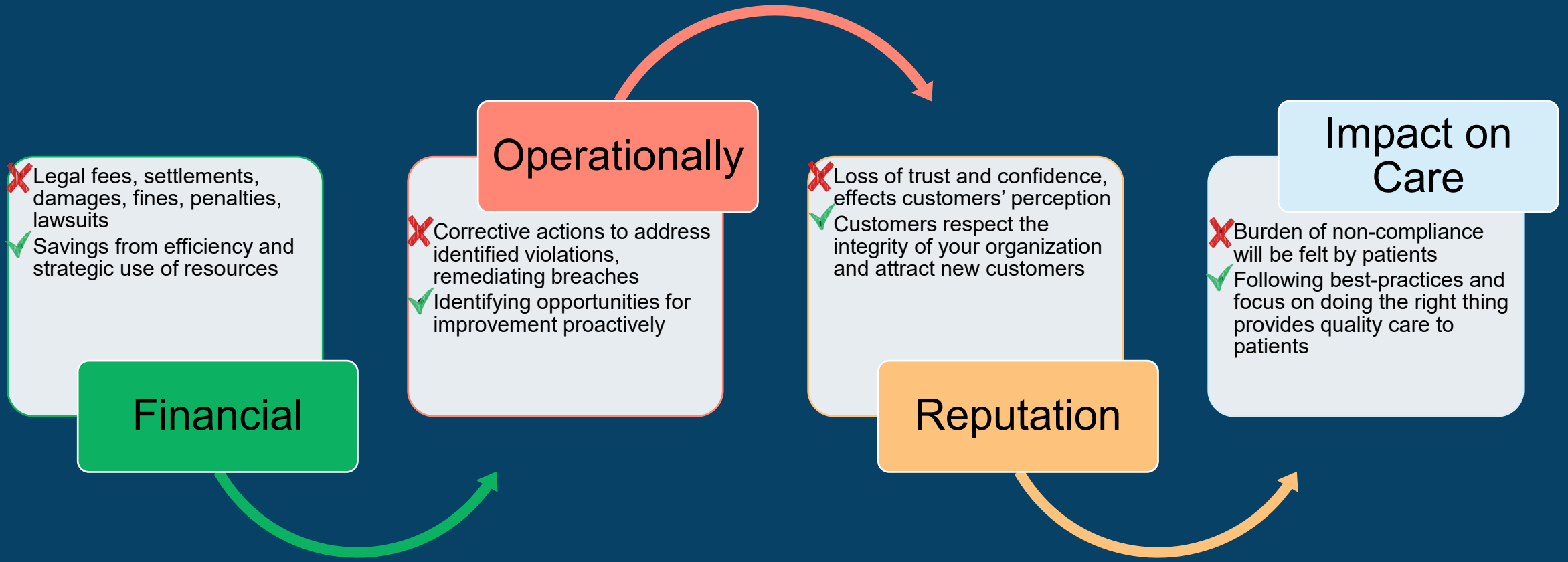
Overpayments



Disciplinary Actions



Provider Sanctions and Penalties



Thank you!

- Questions?
  - Email us at SIU_HHO@highmark.com
- This presentation along with a recording of the live audio will be made available on the Provider Resource Center on our website: https://providers.highmark.com/hho-wv/training-and-education.html.

Resources

Provider Resource Center

- Forms and Reference Materials
- Provider Manual
- Provider Newsletters
- Training and Education

Fraud, Waste and Abuse Website Page

Office of Inspector General – Consumer Fraud

Healthcare Fraud and Scams

West Virginia Department of Human Services Website

CMS Fraud and Abuse Website

CMS Self-Audit Snapshot

OIG Provider Self-Disclosure Protocol