Welcome!

FWA Training with Highmark Wholecare

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

April 16, 2025

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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

This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 17 counties in northeastern Pennsylvania, 13 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Disclaimer

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

Providers may also be required to complete other audits by Highmark Wholecare 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

Highmark Wholecare
Financial Investigations Provider Review ("FIPR")
Special Investigations Unit ("SIU")

Jennifer Putt, CFE, *Manager*

Abigail Zieglar, CFE, *Lead Investigator*

Sandra Leisifer, CFE, *Senior Investigator*

Jennifer Garrity, CFE, *Senior Investigator*

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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
- Examples of FWA
- FIPR Mission
- FIPR Team Functional Areas
- FIPR Functions
- Red Flags

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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 Medicare or Medicaid Program, 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 Medicare or Medicaid Program.
- 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

- Highmark Wholecare's **Financial Investigation and Provider Review ("FIPR")** supports Highmark Wholecare 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 vendor partners.
- FIPR also works with local, state and federal law enforcement agencies to identify and remove unscrupulous providers from our network.

Highmark Wholecare's Mission:
Whole person care - that helps people achieve not just physical health, but whole life health.

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 AHFIs, CFEs and Investigators.
- 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, Financial Investigators and Collections Specialists.
- The team is charged with:
  - Managing vendors
  - Conducting pre-payment reviews
  - Conducting post-payment reviews
  - Collecting provider balances

Compliance & Reporting

- The FIPR Team is responsible for ensuring compliance standards and accurate financial reporting.
- The FIPR Team is comprised of a medical ethicist, CHCs, AHFIs, CFEs, Medical Coders, Financial Investigators, Consultants and Investigators.
- The FIPR Team is charged with:
  - Reporting financial data
  - Implementing an effective FWA program

FIPR Functions

What we <u>DO</u> 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 Highmark Wholecare members
- To ensure services are sustainable in the future

What we <u>DON'T</u> 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
- Anti-Kickback Statute
- Stark Law
- Balanced Budget Act
- Deficit Reduction Act
- Patient Protections and Affordable Care Act
- Civil Monetary Penalties Law
- Other Regulations

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Laws and Regulations: False Claims Act

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. A person is liable to pay damages to the government if he or she knowingly:

- Presents a false claim for payment or approval
- Uses a false record or statement to support a false claim
- Conspires to commit any violation of the FCA
- Uses a false record to avoid or decrease an obligation to pay the government
- Carries out other acts to obtain property from the government by misrepresentation

The FCA penalties and sanctions can include:

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

The FCA includes a *qui tam* provision that 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.

EXAMPLE

On January 24, 2025, pharmaceutical company Pfizer Inc., on behalf of its wholly-owned subsidiary Biohaven Pharmaceutical Holding Company Ltd., agreed to pay nearly $60M to resolve allegations that, prior to Pfizer's acquisition of the company, Biohaven knowingly caused the submission of false claims to Medicare and other federal healthcare programs. The settlement includes the resolution of claims brought under the *qui tam* provisions by Patricia Frattasio, a former sales representative at Biohaven. Office of Public Affairs | Pfizer Agrees to Pay Nearly 60M to Resolve False Claims Allegations Relating to Improper Physician Payments by Subsidiary | United States Department of Justice

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

Laws and Regulations: Anti-Kickback Statute

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, bride or rebate for referrals for services that are paid under a federal healthcare program like Medicaid or Medicare.

- The statute covers both those that offer kickbacks and those that receive kickbacks.
- The illegal kickbacks covered include anything of value and is not limited to just cash.

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.

EXAMPLE

On October 10,2024 Teva agreed to pay $425M to resolve allegations that they paid kickbacks via two co-pay assistance foundations in violation of the Anti-Kickback Statute and FCA. Teva manipulated the co-pay foundation assistance system by conspiring with multiple third parties, including a specialty pharmacy and two co-pay assistance foundations, to direct its supposed charitable payments to patients taking its own MS drug, Copaxone. Teva also raised Copaxone's price by thousands of dollars. District of Massachusetts | Teva Pharmaceuticals Agrees to Pay $425 Million to Resolve Kickback Allegations | United States Department of Justice

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

Laws and Regulations: Stark Law

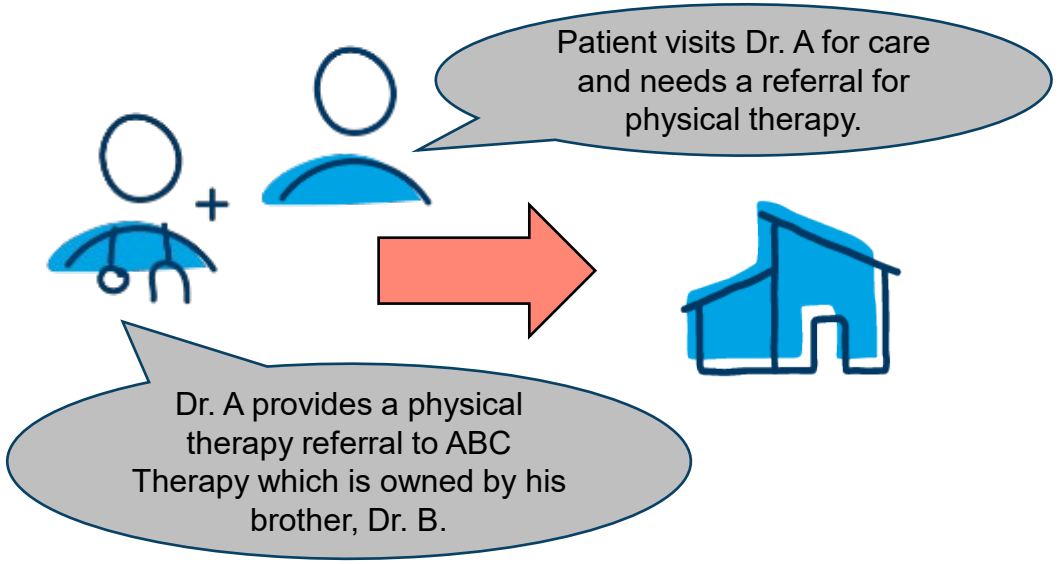
Law that prohibits physicians from referring patients to receive designated health services payable by Medicare or Medicaid from entities with which the physician (or a member of his or her family) has a financial relationship.

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

In March 2024, Dr. Mohammad Athari of Houston TX agreed to pay $1.8M to settle allegations of violating the Stark Law. Dr. Athari and his practice United Neurology P.A. were implicated for a pattern of referring patients to his own diagnostic centers (Universal MRI) between 2014 and 2021. Texas Healthcare Providers Paid $21.3 Million to Resolve Stark Law Violations in 2024

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

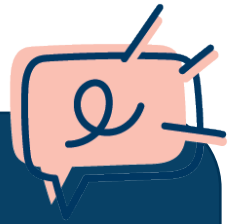
See Public Law 105-33 *for further information*

Laws and Regulations: Affordable Care Act

Referred to as the Patient Access and Affordable Care Act ("ACA"), this Act'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 notable components:

- Establishment of screening requirements for providers and suppliers;
- Expansion of the role of Recovery Audit Contractors to Medicaid and Medicare Parts C and D;
- Requirement of providers to develop a Compliance Plan; and
- Revisions to the False Claims Act and Stark Law



ACA Penalties:

- Harsher civil and monetary penalties
- Increasing Federal sentencing guidelines for healthcare fraud offenses
- New fines and penalties for providers who fail to return overpayments from Medicare and Medicaid within 60 days

See Public Law 111-148 for further information.

Laws and Regulations: 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 as claimed or services not furnished or supervised by a licensed physician
- Making false claims
- Arranging for services or items from an excluded individual or entity
- Presenting claim patterns for medically unnecessary services or items
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Paying to influence referrals
- Knowing of and failing to report and return an overpayment

Penalties can range from $5,000 to $100,000 depending on the specific violation

EXAMPLE

On December 30, 2024, NormaTec Industries, LP from MA, entered into a $198M settlement agreement with the OIG to resolve allegations that an employee of NormaTec improperly created prescribing physicians' orders for durable medical equipment (DME) and medical records supporting the medical necessity of the DME that should have been created by the physician. The submitted claims received payment from Federal healthcare programs using specific HCPCS codes. NormaTec Industries Agreed to Pay $198,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims for DME Supported by Fabricated Medical Records | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

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 due diligence 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

- Compliance Plan
- Provider Screenings
- Provider Self-Audit
- Medical Necessity
- Standards of Practice
- Corrective Action Plans
- Medical Record Requests

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Provider Compliance Plan

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

PA Medicaid Bulletin #99-11-05 requires all providers to screen employees, contractors and subcontractors, individuals and entities, against the exclusion databases as required by forty-two (42) CFR §455.436 to determine if they have been excluded from participation in Medicaid or Medicare. No Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. 42 CFR § 1001.1901(b). Department of Human Services ("DHS") has advised providers to conduct self-audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor, either an individual or entity, to DHS Bureau of Program Integrity ("BPI").

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
- **PA Department of Human Services – Medicheck System:**
  - https://www.humanservices.state.pa.us/Medchk/MedchkSearch/Index

Provider Screenings

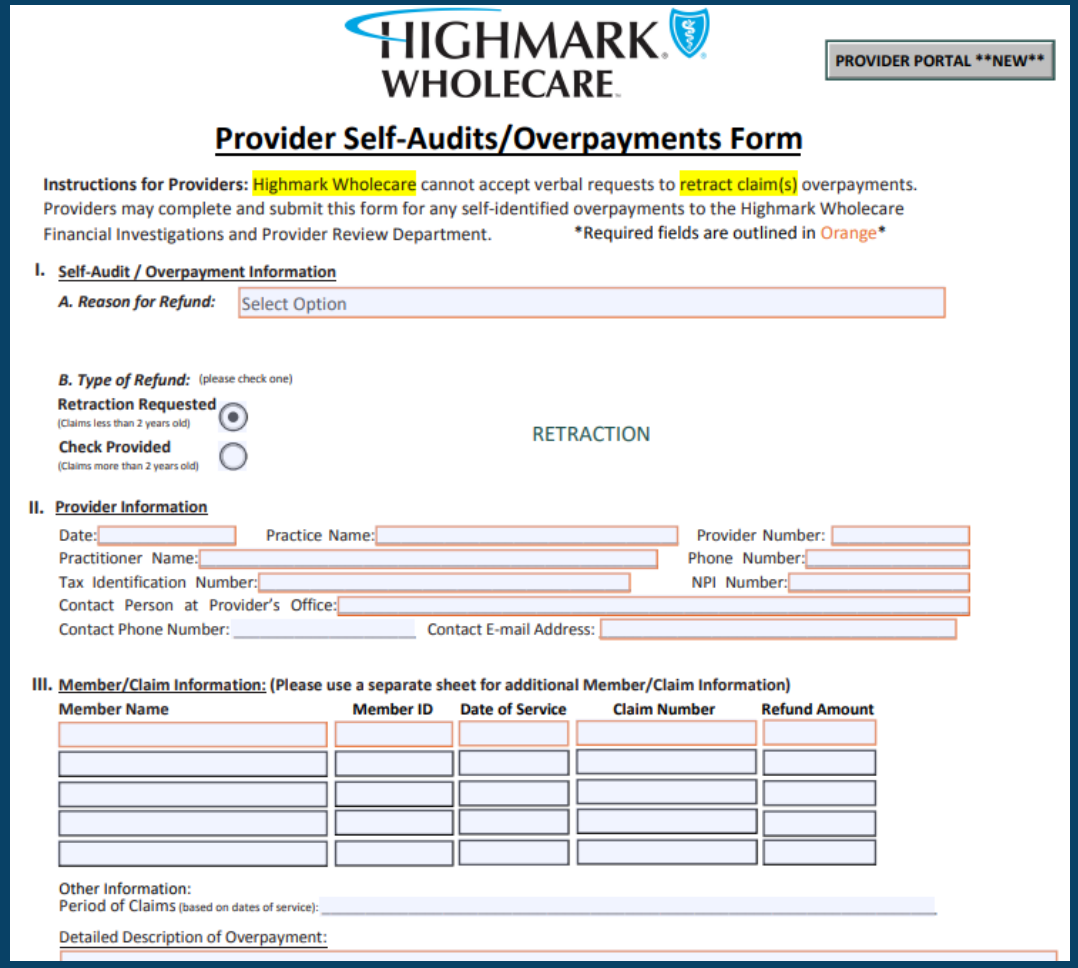
Per provider contracts, Highmark Wholecare requires providers to conduct employee sanction checks, complete all credentialing requirements, review exclusions and conduct criminal background checks of all practitioners and clinicians. Additionally, Highmark Wholecare requires the following verifications:

- A current, unrestricted license
- Fully completed and attested CAQH application
- Active individual MPI number
- 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 participation in the Medicare and Medicaid programs
- ECFMG certificate, if applicable

Provider Self-Audits: Required by DHS and OIG

- Providers can submit overpayments to Highmark Wholecare by using the Provider Self-Audit Overpayment form found on our website
- Both DHS and OIG require providers to conduct self-audits to identify documentation errors and potential overpayments
- Federal and state laws and regulations require overpayments to be returned within ***60 days*** of identification

Resources for Self-Audits:
DHS Guidance
OIG Guidance



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PROVIDER PORTAL **NEW**

Provider Self-Audits/Overpayments Form

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

I. Self-Audit / Overpayment Information

A. Reason for Refund: Select Option

B. Type of Refund: (please check one)

Retraction Requested (Claims less than 2 years old)

Check Provided (Claims more than 2 years old)

RETRACTION

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: SelfAuditOverpaymentsForm 3.0.pdf (highmarkprc.com)

Mail checks with a copy of this form to:

Highmark Wholecare
Attn: FIPR/Melissa Berdell
PO Box 890135
Camp Hill, PA 17089

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

Delivery Code: FIPR
Attn: Melissa Berdell
Highmark Wholecare
120 Fifth Ave.
Pittsburgh, PA 15222

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

- Provider Resource Center (PSAs)
- Medicare Provider Manual
- Medicaid Provider Manual

New 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 Lauren Smith at lsmith@trendhealthpartners.com to initiate access.

Medical Necessity: PA Regulations

55 Pa. Code § 1101.21

- ***Medically necessary—A service, item, procedure or level of care that is:***
  1. **Compensable under the MA Program.**
  2. **Necessary to the proper treatment or management of an illness, injury or disability.**
  3. **Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.**

55 Pa. Code § 1101.21a

- ***A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:***
  1. **Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.**
  2. **Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, Injury or disability.**
  3. **Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.**

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 2025 Medicare Provider Manual

Standards of Practice: PA Regulations

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

Record Requirements

Providers shall maintain medical records that fully disclose the nature and extent of the services rendered to MA recipients and that meet the criteria established in this section and additional requirements established in the provider regulations:

- The record shall be legible throughout.
- The record shall identify the patient on each page.
- Entries shall be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel shall be countersigned by the responsible licensed provider. Alterations of the record shall be signed and dated.
- The record shall contain documentation of the medical necessity of a rendered, ordered or prescribed service.

Additional Standards of Practice

In addition to licensing standards, the Pennsylvania Code establishes basic standards of practice to which every practitioner providing medical care to MA recipients is required to adhere.

- Maintenance of a proper record for each patient.
- A patient's diagnosis, provisional or final, shall be reasonably based on the history and physical examination.
- Treatment, including prescribed drugs, shall be appropriate to the diagnosis.
- Diagnostic procedures and laboratory tests ordered shall be appropriate to confirm or establish the diagnosis.
- Consultations ordered shall be relevant to findings in the history, physical examination or laboratory studies.
- The principles of medical ethics shall be adhered to a rendered, ordered or prescribed service.

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

Highmark Wholecare's 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 Wholecare. 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
- Consent to Treatment
- Release of Information for Payment
- HIPAA and Privacy Practices
- Treatment Plan
- Medication List
- Progress Notes

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Minimum Documentation: Highmark Wholecare Provider Manual

Highmark Wholecare 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 the below 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.

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

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

Pennsylvania Regulations

55 Pa. Code § 1101.75 - Provider Prohibited Acts: (a) An enrolled provider may not, either directly or indirectly, do any of the following acts:

- (10) Except in emergency situations, render or provide a service or item without a practitioner's written order and the consent of the recipient or submit a claim for a service or item which was dispensed or provided without the consent of the recipient

Consent to Treatment forms should be updated yearly, signed and dated by member and provider. If the member is under the age of 18, then a parent or guardian would need to sign a Consent to Treat form on behalf of the member.

For further information regarding minors and consent to treatment, see PA Legislation.

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:

2024 Medicaid Provider Manual

2025 Medicare Provider Manual

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 Highmark Wholecare 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.

Treatment Plan

Pennsylvania Regulations

The PA Code establishes general standards for medical records, including the entry of a treatment plan.

55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

- (v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect

Highmark Wholecare Provider Manual

- 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 included in the 2024 Medicaid Provider Manual and the 2025 Medicare Provider Manual.

Medication List

Pennsylvania Regulations

The PA Code establishes general The Pennsylvania Code establishes standards for medical records, including the entry of a patient's medication

55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

- (v) Treatments as well as the treatment plan shall be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages shall be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's record shall have a notation to this effect

Highmark Wholecare Provider Manual

- 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

These requirements are included in the 2024 Medicaid Provider Manual and the 2025 Medicare Provider Manual.

Progress Notes

Pennsylvania Regulations

The Pennsylvania Code establishes standards for medical records, including the entry of progress notes

55 Pa. Code 1101.51(e)(1): A provider, with the exception of pharmacies, laboratories, ambulance services and suppliers of medical goods and equipment shall keep patient records that meet all of the following standards:

- (vi) the record shall indicate the progress at each visit, change in diagnosis, change in treatment and response to treatment

Highmark Wholecare Provider Manual

- 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

These requirements are included in the 2024 Medicaid Provider Manual and the 2025 Medicare Provider Manual.

Types of Investigations

- Overview
- Routine Investigations
- Routine Audits
- Other SIU Activities
- FWA Solutions

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Types of FWA Activities

- Highmark Wholecare's 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.

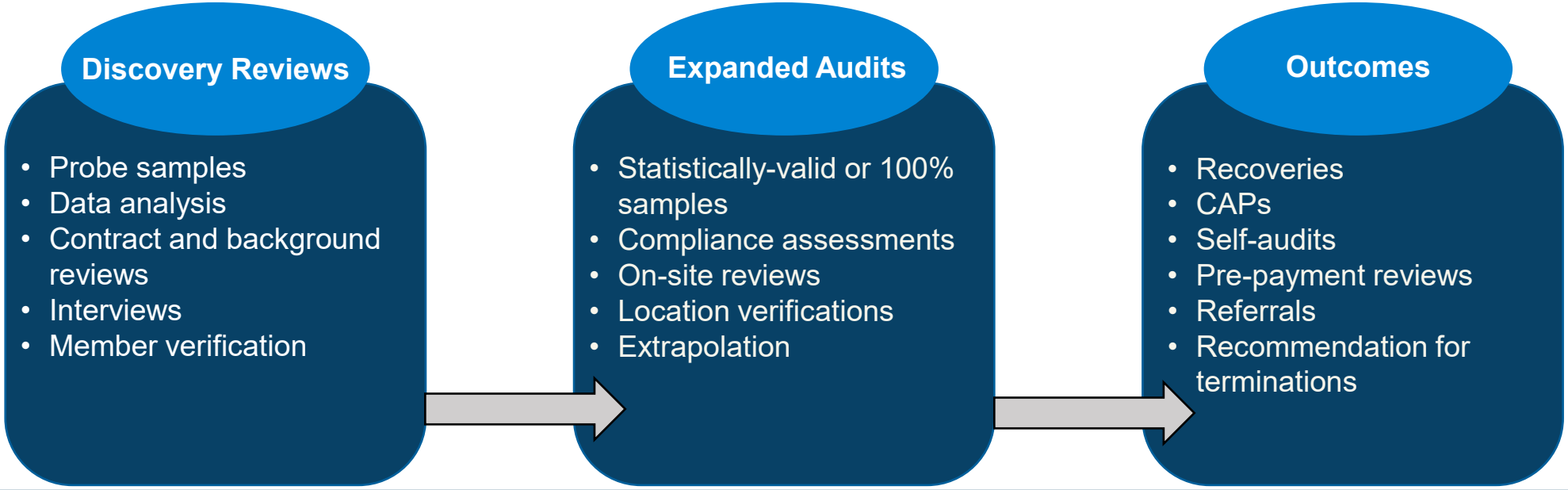
- Conduct Data Analysis
- Review Contract/ Provider Credentialing
- Review Internal Policy for Coding
- Review State/Federal Guidelines
- Member and Provider Interviews

Routine Investigations

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

Routine Audits

- Highmark Wholecare's 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 Wholecare. These requests require MCOs to pull specific information including, but not limited to, claims data, contracts etc.
- **Sources include:**
  - DHS and BPI
  - CMS
  - I-MEDIC
  - OIG HHS
  - Attorney General and MFCU
  - FBI

Provider Education and Training

- Highmark Wholecare's 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 Partnerships

Pre-payment Edits and Reviews

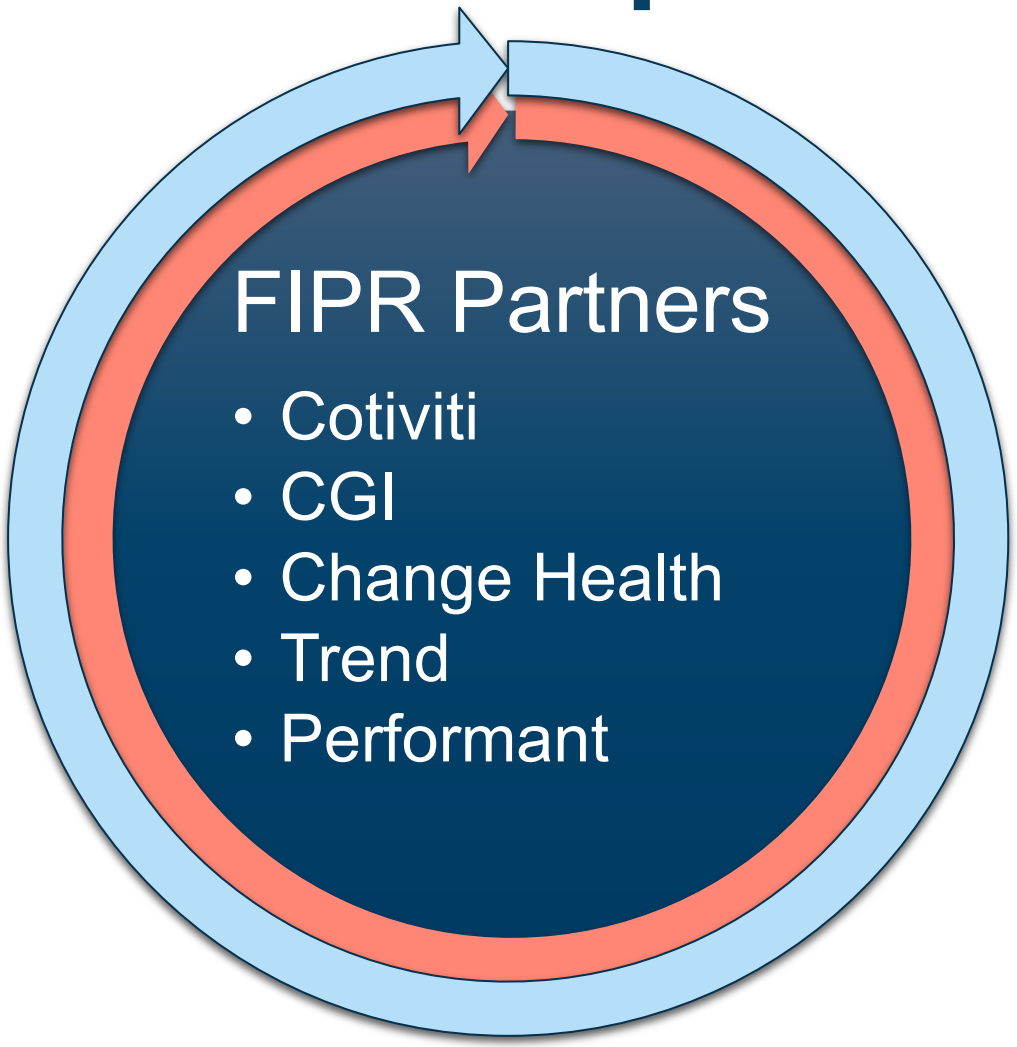
- FIPR contracts with Vendors to monitor claims prior to payment to ensure claims accuracy. FIPR has the capability to suspend claims to conduct pre-payment reviews prior to releasing payment to flagged Providers.

Post-payment Audits

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

Other contracted vendors of Highmark Wholecare 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



Outcomes for Noncompliance

- Overpayments
- Provider Prohibited Acts
- Disciplinary Actions
- Provider Sanctions and Penalties

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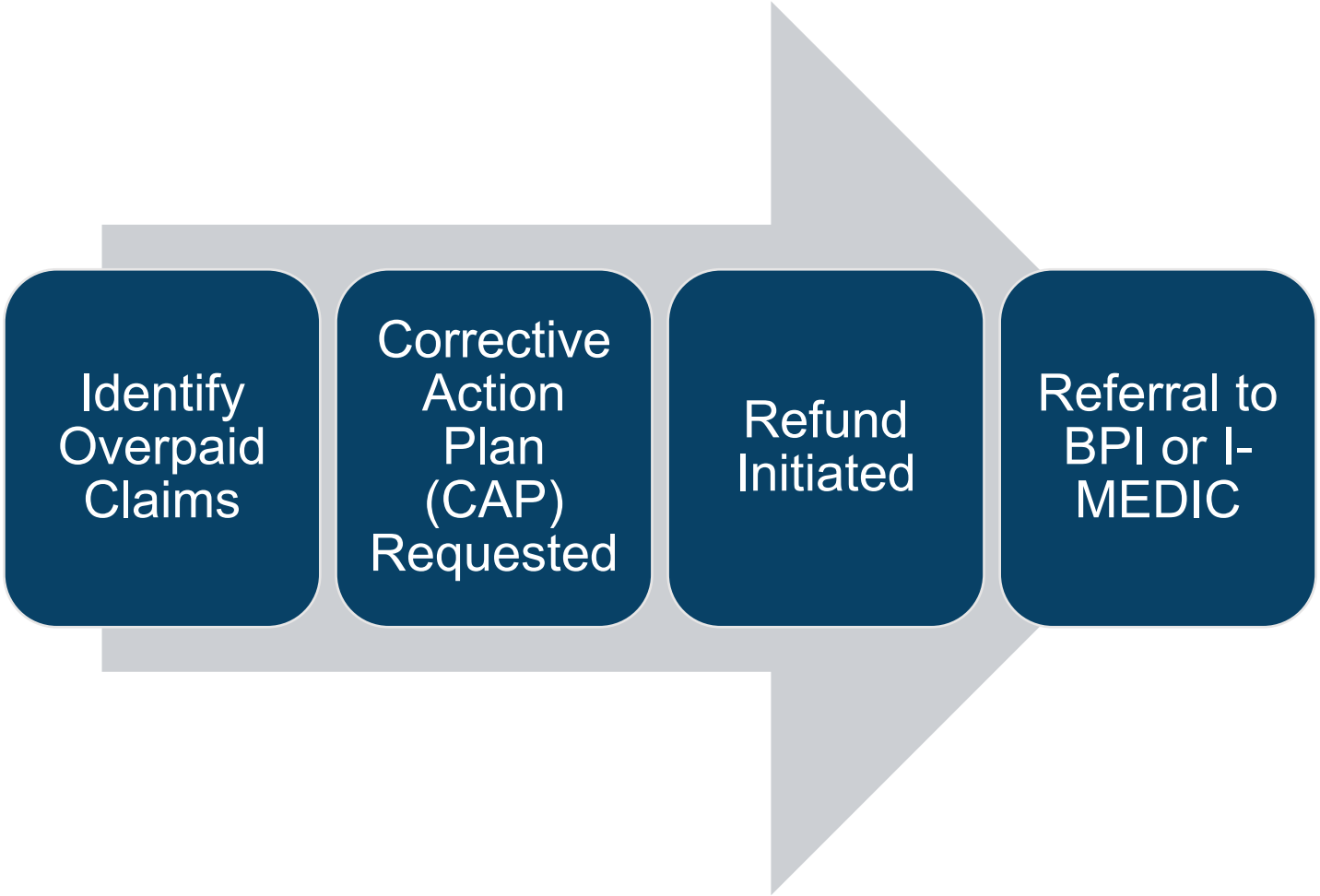
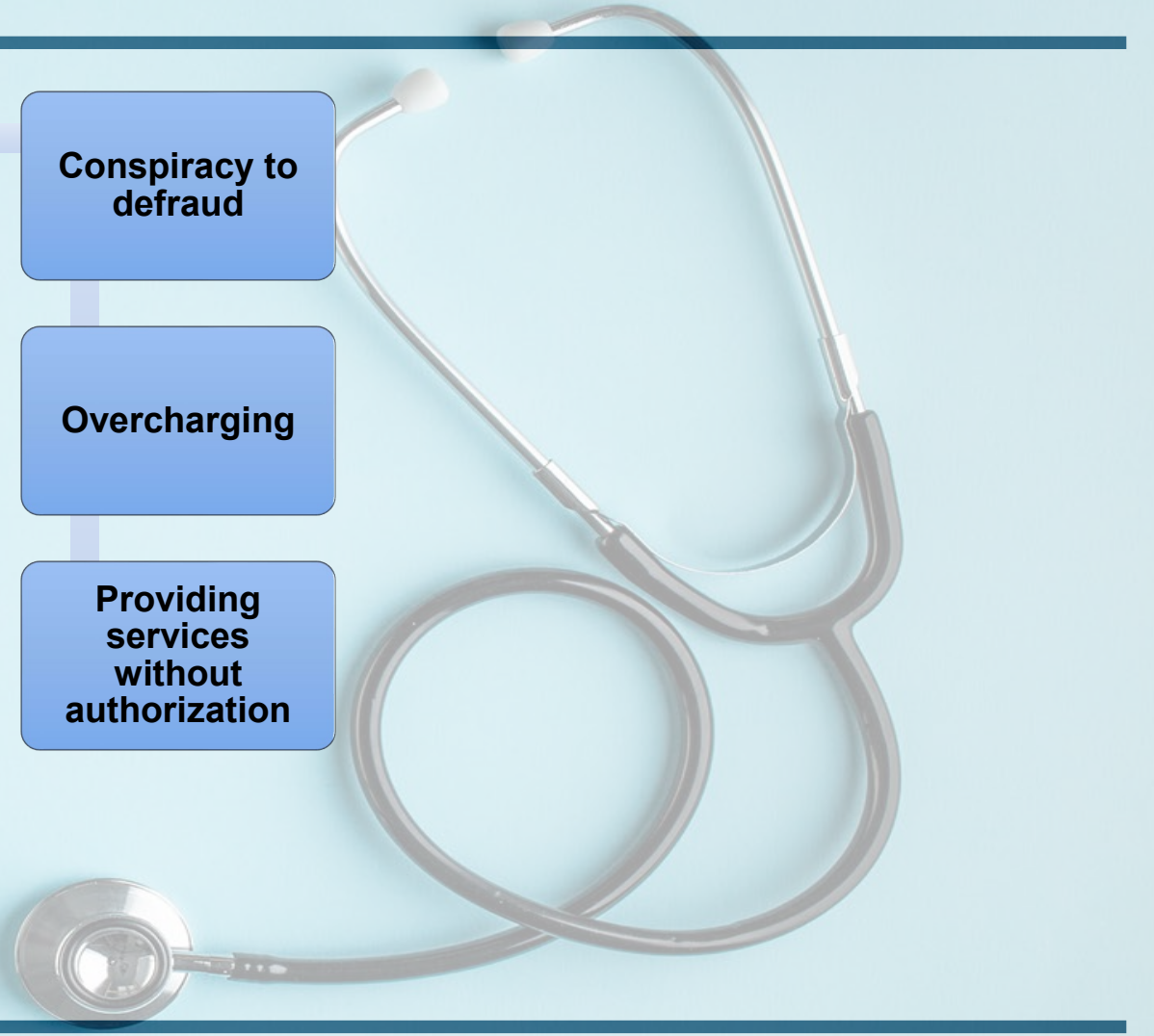
Overpayments

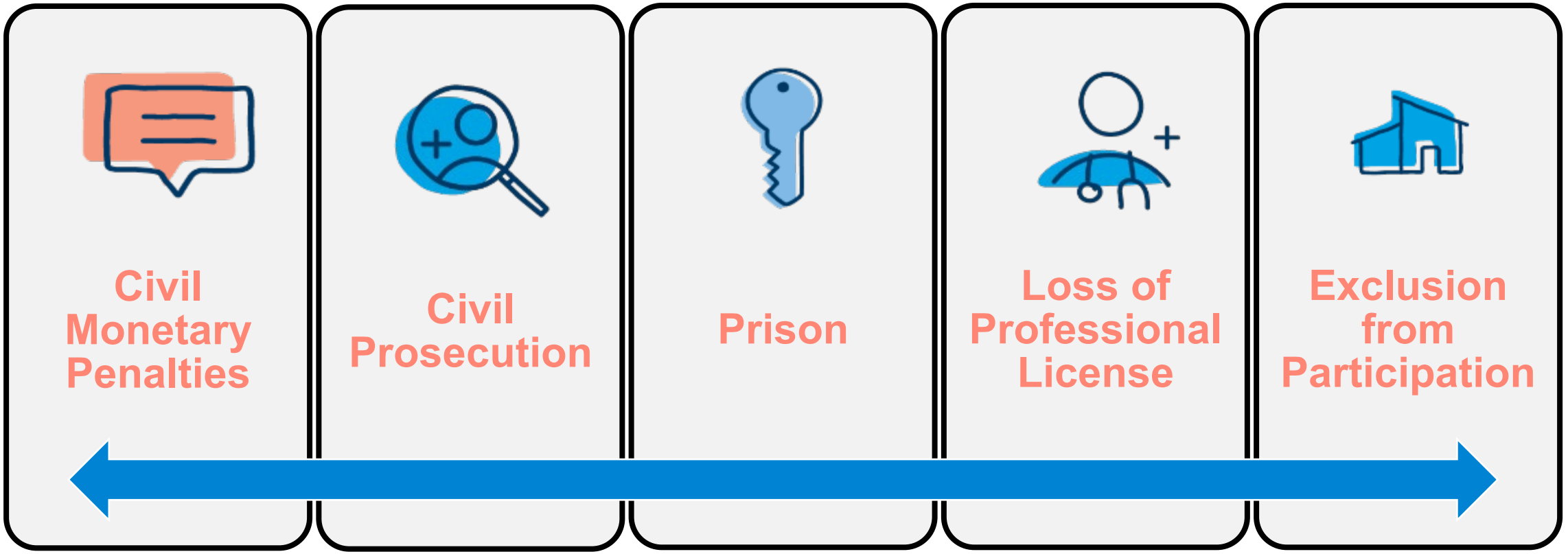


Provider Prohibited Acts
55 PA Code

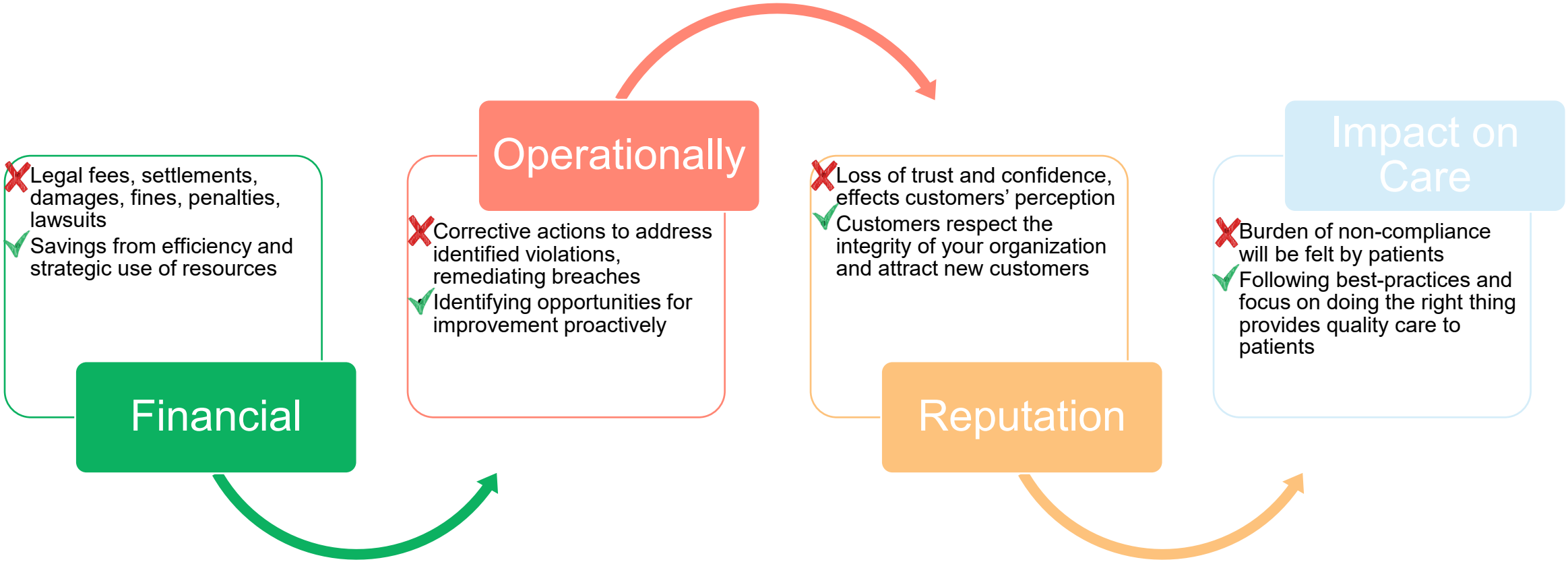
- Fraudulent billing
- False information
- Kickbacks and bribes
- Duplicate claims
- Unrelated charges
- Misrepresenting services
- Claims for unrendered services
- Unnecessary or undocumented services
- Conspiracy to defraud
- Overcharging
- Providing services without authorization



Disciplinary Actions



Provider Sanctions and Penalties



Resources

Medicaid Resource Center

- PA Medicaid Guidelines
- Forms and Reference Materials
- Provider Updates
- Provider Manual

Medicare Resource Center

- Medicare Guidelines
- Forms and Reference Materials
- Provider Updates
- Provider Manual

Highmark Wholecare Fraud and Abuse Website

Office of Inspector General – Consumer Fraud

Healthcare Fraud and Scams

Pennsylvania Department of Human Services Website

MA Program Payment Policies

Provider Responsibilities

DHS Self-Audit Protocol

CMS Fraud and Abuse Website

CMS Self-Audit Snapshot

OIG Provider Self-Disclosure Protocol

Thank you!

- Questions?
  - Email us at SIU@highmark.com
- This presentation along with a recording of the live audio will be made available on the Highmark Wholecare website: https://www.highmark.com/wholecare