Banner University Health Plans | Banner Medicare Advantage

Compliance Handout

Provider Standards and Responsibilities

Banner – University Health Plans (B – UHP) and Banner Medicare Advantage expect all providers, contractors and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- Record Retention Standards

Exclusions Screening

As a registered provider with the AHCCCS Administration (Arizona's Medicaid Program) and/or as a Medicare provider, you are obligated to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. You must complete screening prior to hire or contract and monthly thereafter. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at: http://www.oig.hhs.gov/fraud/exclusions.asp

You are also obligated to search the System for Award Management at: https://www.sam.gov/portal/public/SAM. If an individual or entity is on the exclusion list, you must report it immediately to the Health Plan's Compliance Department.

Preclusion List

The preclusion list is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

CMS made the first Preclusion List available to plans JANUARY 1, 2019 and is issued monthly thereafter.

Plans are required to:

- To reject a pharmacy claim (or deny an enrollee's request for reimbursement)
- For a Part D drug that is prescribed by an individual on the Preclusion List.
- To deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

Federal False Claims Act

- The Federal False Claims Act imposes civil liability on any person or entity that knowingly submits, or causes to be presented to the Government, a false or fraudulent claim for payment or approval.

- It also penalizes anyone who knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay money to the U.S. government. Conspiring with others to commit these acts may also constitute a violation of the FCA.
- This would include fraud involving any federally funded contract or program such as Medicaid and Medicare. The exception is tax fraud. The term "knowingly" includes acting in deliberate ignorance or in reckless disregard of the truth or falsity of the information.
- Submitting claims containing incorrect or inappropriate diagnostic or procedural codes may violate the False Claims Act (FCA).
- Health care providers who are convicted of violating the FCA can be subject to civil monetary penalties ranging from $10,781 to $21,563 for each false claim submitted. In addition, providers can also be required to pay three times the amount of damages sustained by the U.S. government. If a provider is convicted of a FCA violation, the Federal Office of Inspector General may seek to exclude the provider from participating in federal health care programs.

The FCA includes a whistleblower provision, or a "qui tam." This provision allows any person – known as a "relator" – to file a lawsuit on behalf of the U.S. government. A company cannot take action against an employee for initiating a qui tam claim.

Offshore Requirements for Medicaid and Medicare

The term "offshore" refers to work not performed within one of the fifty United States or one of the United States Territories. AHCCCS does not allow any Medicaid activities involving PHI to be performed offshore. This includes the accessing, receiving, processing, transferring, handling, or storing of Medicaid member protected health information (PHI) to be performed offshore. For Medicare, we are required to report any offshore activities to CMS. Common examples are call centers, coding and billing, and transcription services. This also includes subcontracted services.

If you identify or suspect offshore activities at your organization or a subcontractor, immediately notify the Health Plan's Compliance Department.

Provider Requirements

Providers are required to complete a Compliance Attestation Annually (available on B – UHP and Banner Medicare Advantage websites).

Providers must complete annual Compliance and FWA training – can use the Health Plan's training on the website or alternate training but must be able to submit validation of training completion.

The Top Commonly Seen Documentation/Billing Errors

- Progress Notes not Signed and Dated Appropriately
- Services Billed Under the NPI of a Provider who did not render the service for an AHCCCS Service or does not meet the "Incident-To" Rules for Medicare. In some cases, the rendering provider is not credentialed by the Health Plan.
- Upcoding of Evaluation and Management Services
- Diagnoses reported on the claim do not match the provider's assessment

Fraud, Waste and Abuse (FWA)/Compliance Issues

B – UHP and Banner Medicare Advantage strictly enforce fraud, waste and abuse prevention policies and have specific controls in place to prevent and/or detect potential cases of fraud and abuse.

Anyone can report member and/or provider fraud, waste and/or abuse or compliance issues and providers have an obligation to report any fraud, waste, program or member abuse or compliance issues.

Providers are required to report all suspected fraud, waste, and abuse or compliance issues to the Health Plan. Suspected FWA must be reported directly to AHCCCS and can be reported to Medicare directly.

Insurance Division Compliance Program and FWA Plan

The Compliance Program and FWA Plan is updated when there are any significant changes and at least annually. This document is an important resource for providers and includes the Health Plan's Code of Conduct. It can be located on the B – UHP and BMA provider websites at:

- https://banneruhp.com (On the 'Compliance Program' page under the 'Materials and Services' tab)
- https://www.bannerhealth.com/medicare/for-healthcare-providers (On the 'Compliance Program' page)

Other important information is contained on this page. The Compliance Program and FWA Plan spans January 1st through December 31st each year. Providers must have a Compliance Program including Compliance Policies and Procedures and a Code of Conduct.

B – UHP/Banner Medicare Advantage FWA or Compliance Issues

- Customer Care: 800-582-8686
- ComplyLine (24-hour hotline): 1-888-747-7989
- BHPCompliance@bannerhealth.com
- Secure Fax: (520) 874-7072
- Mail: Attn: BHP Compliance Dept., 2701 E. Elvira Rd. Tucson, AZ 85756
- Medicaid Compliance Officer: (520) 548-7862 or Theresa.Dorazio@bannerhealth.com
- Medicare Compliance Officer: (520) 874-2553 or Linda.Steward@bannerhealth.com

Medicaid (AHCCCS) FWA

Report Provider Fraud

- In Maricopa County: (602) 417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or (888) 487-6686
- Or by accessing the AHCCCS website at: https://www.azahcccs.gov/Fraud/ReportFraud/

Report Member Fraud

- In Maricopa County: (602) 417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or (888) 487-6686
- Or by accessing the AHCCCS website at: https://www.azahcccs.gov/Fraud/ReportFraud/

Questions about FWA or abuse of member:

- Email: AHCCCSFraud@azahcccs.gov

Medicare FWA

- Mail: US Department of Health and Human Services, Office of Inspector General, ATTN: OIG HOTLINE OPERATIONS, PO Box 23489, Washington, DC 20026
- Phone: 1-800-HHS-TIPS (1-300-447-8477)
- Fax: 1-800-223-8164
- TTY: 1-800-377-4950
- https://forms.oig.hhs.gov/hotlineoperations