

Guidance for Business Partners

Health Alliance Business Partners are expected to:

- Maintain a compliance plan, which includes policies and procedures that address prevention, detection and correction of fraud, waste and abuse.
- Act with integrity.
- Operate in compliance with all applicable laws and regulations.
- Protect the physical and intellectual property of Health Alliance and any assets entrusted in your care against loss, theft, destruction, misappropriation and misuse.
- Protect the confidentiality of member information. Do not use or disclose member information other than for services provided as outlined in the contract between you and Health Alliance.
- Never offer or accept any bribes, kickbacks or inducements in connection with performing duties for Health Alliance; gifts of money or cash equivalents are never permissible.
- Never pursue a business opportunity or relationship that would compromise Health Alliance ethical standards or violate a law or regulation.
- Respect the rights and dignity of our employees and members. Health Alliance does not tolerate any form of discrimination, abuse, harassment or intimidation in the workplace or with our members.
- Never use any information obtained as a business partner of Health Alliance for personal gain.
- Comply with all relevant government requirements regarding records, documents and data retention.
- Report all suspected misconduct, compliance violations, privacy or security incidents and potential fraud or abuse situations.
- Be free of inappropriate conflicts of interest.

A copy of the *Ethics and Compliance in our Workplace: A Guide to Employee Conduct* is available to you upon request by calling (800) 851-3379 or by clicking [here](#).

Reporting a Compliance Violation, Suspected Misconduct, Privacy or Security Incident or a Potential Fraud or Abuse Situation

If you suspect misconduct or fraud or abuse activity or become aware of a possible violation of federal or state laws, you must report it. You may file a report with any of the following:

Hollie Wilson, VP, Chief Compliance, Risk and Audit Executive
(800) 851-2279 ext. 8824 or (217) 902-8224

Traci Jensen, Director, Corporate Compliance and Enterprise Risk Officer and Privacy Officer
(800) 851-3379 ext. 29152 or (217) 902-9152

Trevor Martin, Director of Information and Cyber Security
(800) 851-3379 ext. 25387 or (217) 902-5387

Special Investigation Unit for Fraud, Waste, and Abuse (FWA) reports to specialinvestigationunit@healthalliance.org

Health Alliance Compliance Line (this avenue can be anonymous)
(217) 902-9134 or (855) 371-4640

The Office of the Inspector General
1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950

Compliance and Fraud, Waste and Abuse Training

The Center for Medicare and Medicaid Services (CMS) requires Medicare Advantage Organizations (MAOs), Part D Sponsors, and Qualified Health Plans to ensure that Compliance and Fraud, Waste and Abuse (FWA) training is conducted for all entities and individuals that meet the definition of first tier, downstream, or related entity.

You may develop and conduct Compliance and FWA training for your staff; however, CMS offers a web-based training course in Fraud, Waste and Abuse available through the MLN Learning Management System. You can access the MLN [here](#).

All providers are required to attest to completion of Compliance and FWA training in addition to other requirements within 90 days of contracting and then annually thereafter. Please click [here](#) to complete the attestation. Once complete, please email this form to your provider relations specialist. This attestation must be completed on a yearly basis. The Compliance Officer, CEO or COO of your organization should complete and sign this form.

Provider Audit Program and Corrective Action Plans

Provider Audit Program

The provisions set forth in the following description of the Provider Audit Program apply to all plans, programs, contractual arrangements and products administered by Health Alliance.

Goals

To proactively analyze claims data and confirm that claim submissions accurately represent the services provided to members and to ensure that billing is conducted in accordance with Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures to combat potential healthcare fraud, waste and abuse.

Objective

To ensure that Health Alliance fulfills its responsibility to its enrollees and/or plan sponsors by identifying and recovering inaccurate payments, which are a result of inadvertent or intentional provider actions or misrepresentations.

Areas reviewed include (but are not limited to):

- Billing for services that were not provided.
- Intentional misrepresentation.
- Billing for services at a higher level than which was rendered.
- Failure to comply with the contract, plan policies and procedures, and/or other relevant guidelines, regulations or laws.
- Inadequate documentation to support the services billed.
- The deliberate performance of unwarranted or medically unnecessary services for the purpose of financial gain.

In connection with the provisions set forth in the contract with Health Alliance, providers shall:

- Provide or arrange for health services for members in an economic and efficient manner consistent with professional standards of medical care generally accepted in the medical community at the time.
- Provide or authorize for members only those services which are medically necessary.
- Maintain complete and up-to-date medical records.
- Bill in accordance with CPT guidelines and HCPCS guidelines.
- Comply with all Health Alliance payment policies.

In connection with the preceding provisions, Health Alliance's Provider Audit Program may:

- Audit providers.
- Recover funds from providers who engage in improper and/or inappropriate billing practices (*Although audits are usually based on claim submissions for up to a five-year period, audits and medical record requests will only be subject to a five-year request. Recoupment requests will extend back no further than one year from the payment date*).
- Suspend future claim payments once improper billing practices are suspected.
- Close the provider's panel or terminate the provider in addition to recovering overpayments if the provider intentionally engages in improper billing practices.
- Access medical records of past and present Health Alliance members.

Note: Providers shall grant Health Alliance access to review and copy member medical records within 30 days from Health Alliance's initial request for access, unless a different time period is mutually agreed upon by Health Alliance and the provider.

Corrective Action Plans

A Corrective Action Plan (CAP) is a plan of action developed by a provider to address findings and observations that have been identified by Health Alliance during a desk or field audit. The CAP gives a provider the opportunity to identify, analyze and address the root causes of the findings

and observations to ensure future billing and/or documentation compliance with Health Alliance.

When a provider submits a CAP, the Health Alliance Compliance Officer or designated staff will review it and determine whether the specific corrective action for each audit finding and/or observation meets the requirements for approval.

Health Alliance will provide a letter of acceptance or denial to the provider based upon the submitted CAP.

Corrective Action Plans Denials

Health Alliance may deny a submitted CAP if it:

- Fails to address the specific findings/observations.
- Fails to provide a specific plan of corrective action for each deficiency.
- Contains argument or refutation of findings/observations.
- Fails to identify the person(s) responsible for implementation.
- Fails to identify target dates, including implementation and completion dates.

A follow up review may be conducted after the CAP is accepted to ensure compliance and implementation of the CAP.

Any follow up reviews must show adequate corrections of the deficiencies and/or monetary recoupment otherwise termination of a provider contract with referral to an appropriate government agency could occur.

HIPPA Privacy – PHI Authorization Process

HIPPA Privacy Policy for Use, Protection and Disclosure of PHI

Health Alliance (covered entity) complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. The Privacy Rule ensures a patient's protection of privacy without hindering his or her access to quality health care.

As a health care provider (covered entity) you are required to comply with HIPAA Privacy and Security Rules. As a contracted provider of Health Alliance you are also required to protect member/patient PHI based on contract

provisions. You must safeguard the privacy of any information that identifies a particular member. You must take reasonable precautions to maintain the confidential nature of and to prevent the disclosure of confidential records or information. This includes the disclosure of medical records relating to members to other than individuals authorized to receive such information pursuant to valid releases, lawful court orders, lawful subpoenas or in accordance with federal or state laws. If required by law, you are responsible for obtaining and maintaining adequate release of information authorizations from members essential for the administration of benefits under the member's plan.

As covered entities under HIPAA, we are allowed to use members/patients Protected Health Information (PHI) as allowed by the Privacy Rule and we are allowed to disclose PHI to one another for treatment, payment and certain health care operation activities.

Payment and certain health care operation activities include:

- Submission and receipt of claims for reimbursement.
- Billing and claims management.
- Health care data processing.
- Disclosure and receipt of medical record information for review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges.
- Utilization review activities, including preauthorization, concurrent and retrospective review of services.
- Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines.
- Population-based activities relating to improving health or reducing health care costs.
- Protocol development, case management and care coordination.
- Contact with health care providers or patient/member with information regarding treatment alternatives.
- Review of competence or qualifications of health care professionals and evaluation of practitioner, provider or health plan performance.
- Accreditation, certification, licensing or credentialing activities.
- Fraud and abuse detection and compliance programs.

If authorization by the member is required before releasing PHI (for example, for mental health records), Health Alliance will obtain a completed and signed

[Member Authorization to Disclose Protected Health Information form](#) from the member and send it to you along with our request for the PHI.

Click [here](#) for a copy of our Notice of Privacy Practices that describes how we protect this information.

Overpayment Recoupment Requests

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage plans to make a determined effort to prevent, detect and correct health care fraud, waste and abuse. Health Alliance has selected Cotiviti as a partner in our ongoing effort.

Cotiviti performs overpayment analysis on all Health Alliance claims. Provider offices may see recoupment requests (based on national coding standards) and medical record requests from Health Alliance or Cotiviti. The requests are based on audits performed on billing errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The audits are performed following government and industry rules, regulations and policies governing health care claims. The findings within the letters are based upon nationally recognized and accepted sources, including American Medical Association CPT Guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

Providers may appeal the findings in the recoupment requests by following the appeals process in the Appeals section of this manual.