18 – Fraud, Waste and Abuse Compliance Policy

Activities that are considered fraud, waste and abuse by members, practitioners or care providers hurts everyone – SHL, taxpayers, members and providers. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud or abuse. Your assistance in notifying us and cooperating with any potential fraud or abuse occurrence is vital and appreciated in conjunction with our mutual ongoing efforts to coordinate the most effective health outcomes possible for our members.

Definitions of Fraud, Waste and Abuse
Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care 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 health care benefit program.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of Potentially Fraudulent, Wasteful or Abusive Billing include, but are not limited to:

- **Back filling:** Billing for part of the global fee before the claim is received for the actual global code.
- **Billing for services not rendered:** Billing for services or supplies that were not provided to the member.
- **Billing for unauthorized services or equipment:** Billing for ancillary, therapeutic or other services without a required physician's order.
- **Billing while ineligible:** Billing for services after care provider's license has been revoked/restricted or after a care provider has been debarred from a government benefits program for fraud or abuse.
- **Double billing:** Billing more than once for the same service.
- **Falsified documents:** Submitting falsified or altered claims or supporting claims with falsified or altered medical records and/or supporting documentation.
- **Looping:** Submitting claims for various family members when only one member is receiving services.
- **Misrepresentation:** Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for non-covered services.
- **Patient brokering:** Using "brokers" who offer money to subscribers for the use of their ID cards.
- **Phantom billing:** Billing by a "phantom" or non-existent care provider for services not rendered.

- **Unbundling:** Billing each component of a service when one comprehensive code is available.
- **Up-coding:** Billing at a higher level of service than was actually provided.
- **Waiver of copay:** Choosing not to collect copayments or deductibles as part of the payment agreement.

If you identify potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. There are multiple reporting methods including:

SHL Provider Services - 702-242-7088
The Compliance & Ethics Help Center
–Phone: 1-800-455-4521 (US)
–Online: www.uhghelpcenter.ethicspoint.com
–The Help Center is available 24 hours a day, 7 days a week.
Health Care Fraud Tip Line
-Phone: 1-866-242-7727
-Email: UHCNV-Medic-FWA@uhc.com
UnitedHealth Group Compliance & Ethics Office
–Phone: 1-952-936-7463
–Email: ethicsoffice@uhg.com

Prevention and Detection
We help prevent and detect potential FWA through many sources. These include:
- UnitedHealthcare Payment Integrity functions
- Optum Companies within UnitedHealth Group
- Health care providers
- Health plan members
- Federal and state regulators and task forces
- News media
- Professional anti-fraud and compliance associations
- CMS Web Sites: https://sam.gov/SAM/

We also monitor and audit prevention and detection by:
Prospective Detection:
- Pre-Payment Data Analytics
- Data Mining Queries
- Abnormal Billing Patterns
- Other activities to determine if we need additional prospective activities.

Retrospective Detection:
- Post-Payment Data Analytics
- Payment Error Analytics
- Industry Trend Analysis
- Care Provider Audits

Corrective Action Plans
As a part of our payment integrity responsibility, we evaluate the appropriateness of paid claims. We may initiate a formal corrective action plan if a provider does not comply with our billing guidelines or performance standards. We will monitor the plan to confirm that it is in place and address any billing/performance problems.

Beneficiary Inducement Law
The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of HIPAA. The law makes it illegal to offer money, or services that are likely to influence a member to select a particular care provider, practitioner, or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment.
- Waiving copayments and deductibles

Care providers who violate this law may be fined up to $10,000 for each wrongful act. Fines may be assessed for up to three times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities
Items or services offered to members for free must be worth less than $10 and total less than $50 per year per beneficiary. Never give cash or gift cards to members.

Required Training
As part of an effective Compliance Program, CMS requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including SHL, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their employees, including the CEO, senior administrators or managers, and for governing body members, and for first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties.

The required education, training, and screening requirements to which we – and you – are subject include the following:

Standards of Conduct Awareness
FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group's (UHG's) Code of Conduct (found at http://www.unitedhealthgroup.com/~/media/UHG/PDF/About/UNH-Code-of-Conduct.ashx) to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

What You Need to Do for Standards of Conduct Awareness
Provide your own or the UHG's Code of Conduct as outlined above and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste, and Abuse and General Compliance Training
FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide Fraud, Waste, and Abuse (FWA) and General Compliance training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

Effective January 1, 2016, CMS requires the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization. The CMS standardized FWA training and education module is available through the CMS Medicare Learning Network (MLN) at cms.gov.

FDRs meeting the FWA certification requirements through enrollment in the fee-for-service (Parts A or B) Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

What You Need to Do for FWA and Compliance Training
Administer FWA and General Compliance training as outlined above and maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), employee attestations or electronic certifications from employees that include the date of the training) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Exclusion Checks
FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers, volunteers, and consultants), the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded or become excluded from participating in Federal health care programs.

FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at http://oig.hhs.gov/exclusions/index.asp

General Services Administration (GSA) Excluded Parties Lists System at https://www.sam.gov

What You Need to Do for Exclusion Checks
Review applicable exclusion lists as outlined above and maintains a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.