Priority Health™

Compliance Education

Revised 11-3-25

01

Compliance Program

Priority Health

What is a Compliance Program?

A compliance program safeguards the organization's legal responsibility to abide by applicable laws and regulations. A compliance program also helps the organization live its values and ethics.

Our Compliance program is in accordance with the **Seven Elements of an Effective Compliance Program.**

Priority Health

What does this mean at Priority Health?

Seven elements of an effective compliance program	How our compliance program meets the element requirements
1. Implementing standards of conduct, policies and procedures	Our Code of Excellence sets clear expectations. Policies and procedures are integral to our operations and essential tools to help detect, prevent and correct potential compliance issues.
2. Establishing compliance oversight	Compliance Officers and board of directors through their Compliance Committees implement, monitor and oversee the compliance program.
3. Conducting effective training and education	Education is provided to ensure knowledge of federal, state and local regulations, accreditation standards and contractual obligations to assist in addressing key risk areas.

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What does this mean at Priority Health?

Seven elements of an effective compliance program	How our compliance program meets the element requirements
4. Developing effective lines of communication	Compliance is here as a resource and partner.
5. Conducting internal monitoring and auditing	Performing planned audits, onsite visits, interviews and routine monitoring helps identify emerging risks as well as resolve issues in previously identified areas.

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What does this mean at Priority Health?

Seven elements of an effective compliance program	How our compliance program meets the element requirements
6. Enforcing standards through disciplinary guidelines	The compliance department in conjunction with human resources established standardized guidelines for a fair and consistent approach to managing performance and conduct issues.
7. Investigating and remediating issues	All reports of concerns or issues are reviewed and investigated by the compliance department and other partnering departments who collaborate throughout the process to ensure each report is resolved.

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Reporting

Our *Code of Excellence* outlines the values and policies we must follow in order to ensure the integrity of our actions that help our health plan members and help evolve the model of care. If you have any questions about compliance or fraud, waste and abuse, or want to report an incident:

Heather DeHaan	Brenda Gross	TBD
Compliance & Privacy Officer	Director, Special Investigations Unit	Director, Medicare Compliance Officer
Heather.DeHaan@priorityhealth.com	Brenda.Gross@priorityhealth.com	
PHCompliance@priorityhealth.com	SIU@priorityhealth.com	PHCompliance@priorityhealth.com
616.464.3510	616.464.8152	

Or call the Compliance Helpline at 800.560.7013. This third-party organization is open 24 hours a day, and they'll report your concern to us.

For additional reporting options, or to report to applicable external agencies (HHS OIG, MDHHS OIG, EHB OIG) https://www.priorityhealth.com/member/understanding-your-benefits/help-avoid-fraud-waste-and-abuse

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Priority Health Code of Excellence?

Our Commitment to Ethics and Integrity

- What we do matters. As a health system, we can **improve health, instill humanity and inspire hope**. How we go about fulfilling our mission also matters.
- Our Code of Excellence sets clear expectations for how we act and make decisions every day. The core principle of our Code is: **We do the right thing.**
- Doing the right thing means we speak and act in accordance with our values. When we're unsure of what's right, we ask for help. When there are different ways to achieve the right outcome, we seek to make the best decision possible, guided by our values and knowledge. We do the right thing even if no one notices or is watching and even if it's not the easy thing to do.
- By embracing and living this Code, each of us contributes to a culture of trust and transparency, innovation and continuous improvement, compassion and generosity. Each of us helps establish our system as one that welcomes all, encourages everyone to contribute, and is dedicated to solving the tough issues our patients and health plan members' encounter.

Mission
Improve health, instill humanity and inspire hope.

Vision
A future where health is simple, affordable, equitable and exceptional.

Values
Compassion. Collaboration. Clarity. Curiosity. Courage.

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Priority Health Code of Excellence

The Code of Excellence
This Code of Excellence (Code) applies system-wide to all employed and non-employed team members (collectively referred to as team members) including providers, contractors, consultants, agents, students, volunteers and suppliers.

1. **We follow the highest standards of ethics and integrity.** This includes conducting ourselves in accordance with our values, adhering to all professional standards for responsible and ethical business practices and complying with all laws and regulations governing our business.
2. **We make sure everyone has a voice.** We raise concerns and evaluate them in a fair and just manner. We do not allow retaliation against anyone seeking help or raising a concern in good faith. When human error happens, we support our team members through a non-punitive response.
3. **We treat everyone with compassion, dignity and respect.** We serve everyone in our communities, without regard to race, color, sex, national origin, disability, age, HIV status, marital status, sexual orientation, gender identity, gender expression, religious beliefs, sources of payment for care or other protected status or category. We work to create environments free of harassment, violence and intolerance.
4. **We prioritize team member wellbeing and foster belonging.** We promote a positive, supportive environment where each team member feels valued and included. We act in safe and healthy ways and perform our duties with clarity and focus.
5. **We are good stewards of our resources.** These resources include our people, facilities, funding, information, technology, equipment, and supplies. We use them responsibly, and ensure that others do, too. We share them or allow others access to them only for legitimate business purposes and with proper authorization.
6. **We code and bill our services appropriately.** We strive to ensure and maintain complete and accurate documentation of medical services provided. We expect accurate coding from our provider partners. We report and return any overpayment from a government health care program, commercial payer, or patient.
7. **We are transparent with quality and pricing.** We give clear and accurate information as it relates to charges for the items and services we provide. We proactively share information about the quality of our care, the outcomes of our services, and the experiences of our patients and health plan members. We attempt to answer questions and resolve disputes related to our services to the patient's, health plan member's and payer's satisfaction.
8. **We protect the privacy of our patients and health plan members.** We collect information about a patient's and health plan member's medical condition, history, medication and family illnesses to provide the best possible care and health plan services. We protect individuals' health information while allowing the flow of information needed to provide and promote high quality health care.
9. **We are honest, accurate and fair in our business relationships.** We provide true and accurate information to the public, regulatory agencies, news media, and others who have an interest in our activities. We engage in social media in a way that is truthful and respectful of others. We follow our policies and principles of good business ethics pertaining to the exchange of gifts and business courtesies with suppliers. We address potential conflicts of interest before they arise, and when they do arise, we manage them through disclosure and removing the individual(s) with the conflict from decision-making related to the interest or matter.

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02

Fraud, Waste and Abuse

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Fraud, Waste and Abuse

Fraud, waste and abuse (FWA) increase the cost of health care and can cause harm to our health plan members. As Priority Health team members, we are all responsible for fighting FWA. This training will increase your awareness so you can support the prevention and detection of FWA, and you will learn how to report suspected cases of FWA.

Fighting FWA is important for all of our products including our Medicare Advantage, Medicare Part D, and Medicaid because these products are vulnerable to practices that result in significant fraud and abuse.

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FWA Overview

- Fraud, waste and abuse (FWA) imposes an enormous cost to our health care system.
- While it's difficult to get an exact number, the National Health Care Anti-Fraud Association (NHCAA) conservatively estimates that health care FWA account for as much as 3% of total health care expenditures.
- U.S. health care spending grew 2.7% in 2021, reaching $4.3 trillion. This means that an estimated $120 billion may be lost in FWA annually.
- FWA affects everyone – individuals and businesses alike. In addition, to the higher premiums and increased out-of-pocket costs, it can compromise the quality of care our health plan members receive.

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General Definition

Fraud means an intentional deception or misrepresentation that the individual knows to be false and knows that the deception could result in some unauthorized benefit to himself / herself or to some other person.

Waste means overusing services or other practices that directly or indirectly result in unnecessary costs. Waste is generally considered to be the misuse of resources due to improper management, practices, or controls.

Abuse means practices that are inconsistent with accepted sound fiscal, business or practices and result in unnecessary cost or in reimbursement for services that are not medically necessary. In the case of abuse, the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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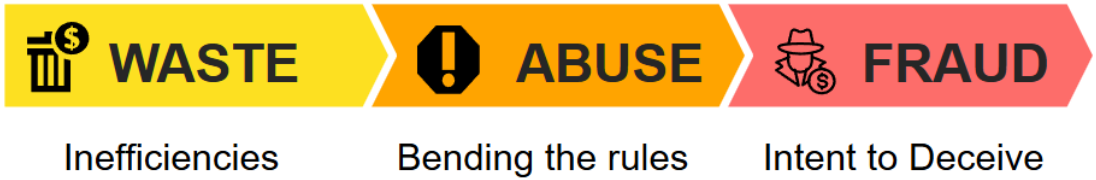
What's the difference?

The difference between FWA is understood by examining knowledge and intent.

Fraud requires that the person has intent to obtain payment and the knowledge that their actions are wrong.

Waste and abuse may involve obtaining an improper payment but do not require the same intent and knowledge. However, if a provider engages in repeated abuse after being educated, then abuse could be viewed as fraud.



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Perpetrators of Fraud and Abuse

Most individuals in the health care industry are honest, hardworking, and law-abiding. However, fraud and abuse can emerge from all sectors of the industry, and anyone of these individuals can engage in bad behavior.

- Providers
- Subscribers / Health Plan Members
- Group Health Plans
- Medicare Stakeholders
- Agents / Brokers
- Imposters
- Pharmacists
- Pharmaceutical Wholesaler
- Pharmaceutical Manufacturer

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Victims

People who engage in fraud or abuse sometimes defend their actions by saying that “It doesn’t hurt anyone,” or “I’m only ripping off the insurance industry.” The truth is that FWA hurts just about everyone.

Honest Providers:

Widespread news stories involving provider fraud have already harmed the public’s trust in health care professionals. In addition, provider fraud can lead to unnecessary audits for honest providers.

Taxpayers:

Like other health plans, tax-funded programs such as Medicare and Medicaid, lose cash and resources to health care FWA.

Employers:

FWA causes Priority Health to lose money. We also lose resources and time to fight against it.

Health Plan Insurers:

Often pay most of the cost for employee health benefits programs. Therefore, fraud and abuse are big contributors to the high prices faced by employers and their workers.

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Who are Victims of FWA?

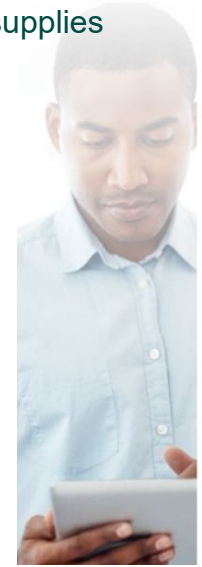
Patients are victims of FWA and are harmed the most. Fraud can be a traumatic experience that often causes real and irreversible impacts.

Premiums increase: FWA increases the cost of everything, including treatment, prescription drugs, medical supplies and equipment.

According to the National Health Care Anti-Fraud Association, health plans lose billions of dollars every year to fraud and abuse and spend millions more trying to fight the problem.

The costs associated with health care fraud and abuse are passed on to health plan members in the form of higher premiums.

Benefit limits are reached too soon: Providers who engage in fraudulent billing or perform unnecessary surgeries can cause their patients to reach their benefit limits too soon (for example: physical therapy limits).



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Who are Victims of FWA?

Unnecessary treatment put patients at risk: Physicians who perform unnecessary treatment can put a patient's life in danger or contribute to permanent disability.

Even when patients fully recover, they may still lose time at work and face needless hardship.

Medical records can be compromised: Providers who charge or falsify diagnoses to increase reimbursement or justify expensive treatment or equipment may also be harming their patients' future.

Patients who are falsely diagnosed with serious illnesses can find it harder to find affordable health benefit coverage.

In some cases, a phantom illness or exaggerated diagnosis can make it harder for patients to find future employment.

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Fraud, Waste and Abuse Laws

The following key laws are in place to combat FWA and to protect the integrity of the health care payment system.

- HIPAA
- Federal & State False Claims Act
- Anti-Kickback Statute (AKS)
- Stark Law
- Beneficiary Inducement Law
- Civil Monetary Penalties Law

Enforcers of FWA Laws

- Department of Justice (DOJ)
- Department of Health & Human Services Office of Inspector General (OIG)
- Centers for Medicare & Medicaid Services (CMS)
- Michigan Department of Health & Human Services Office of Inspector General (OIG)

Federal False Claims Act (FCA)?

Prohibits the submission of false of fraudulent claims for payment to the federal government. The submitter is liable for the amount wrongfully paid. And, could be fined three times the amount plus civil penalties for every false claim.

Examples of a FCA violation:

- Submitted a claim when you know the system is plagued with errors and will cause an erroneous claim.
- A claim is submitted for services a provider did not render.

Expansion under the Affordable Care Act (ACA):

- If Priority Health receives funds under a federal program to which we are not entitled, we must report and return this within 60 days of identification.
- Liability is expanded to include payments associated with an Exchange if the payments include any federal funds.

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Michigan Medicaid False Claims Act (MMFCA)

The MMFCA is a state law that is designed to prevent fraud, kickbacks and conspiracies in the Michigan Medicaid program.

- Allows any person to file a civil lawsuit to recover losses to the state of Michigan. Such persons are called “whistleblowers.”
- Contains important protections for whistleblowers who file claims in good faith. Retaliatory conduct against an employee who either files under the MMFCA or cooperates in an MMFCA lawsuit may entitle the employment, back pay and compensation for costs or damages.

Blowing the Whistle

A whistleblower is a person who *reports in good faith* information or activity they believe to be a violation of a law, rule or regulation.

Using the “qui tam” provisions that are a part of law, any person may file a lawsuit on behalf of the government in federal court.

Once filed, the lawsuit is kept confidential or “under seal” while the government investigates the allegations and decides how to proceed.

If the government decides that the lawsuit has merit, it may intervene. In this case, the U.S. Department of Justice will try the case.

The government may decide not to intervene. In this case, the whistleblower would have to continue with the lawsuit on his or her own.

Rewards for Whistleblowers

- If the lawsuit is successful, the whistleblower may receive an award ranging from 15-30% of the amount recovered.
- The whistleblower may also be entitled to reasonable expenses, such as attorney fees.
- If a court finds that the whistleblower planned or initiated the false claims, the award may be decreased. If the whistleblower is convicted of crimes related to the false claims, no award will be given.

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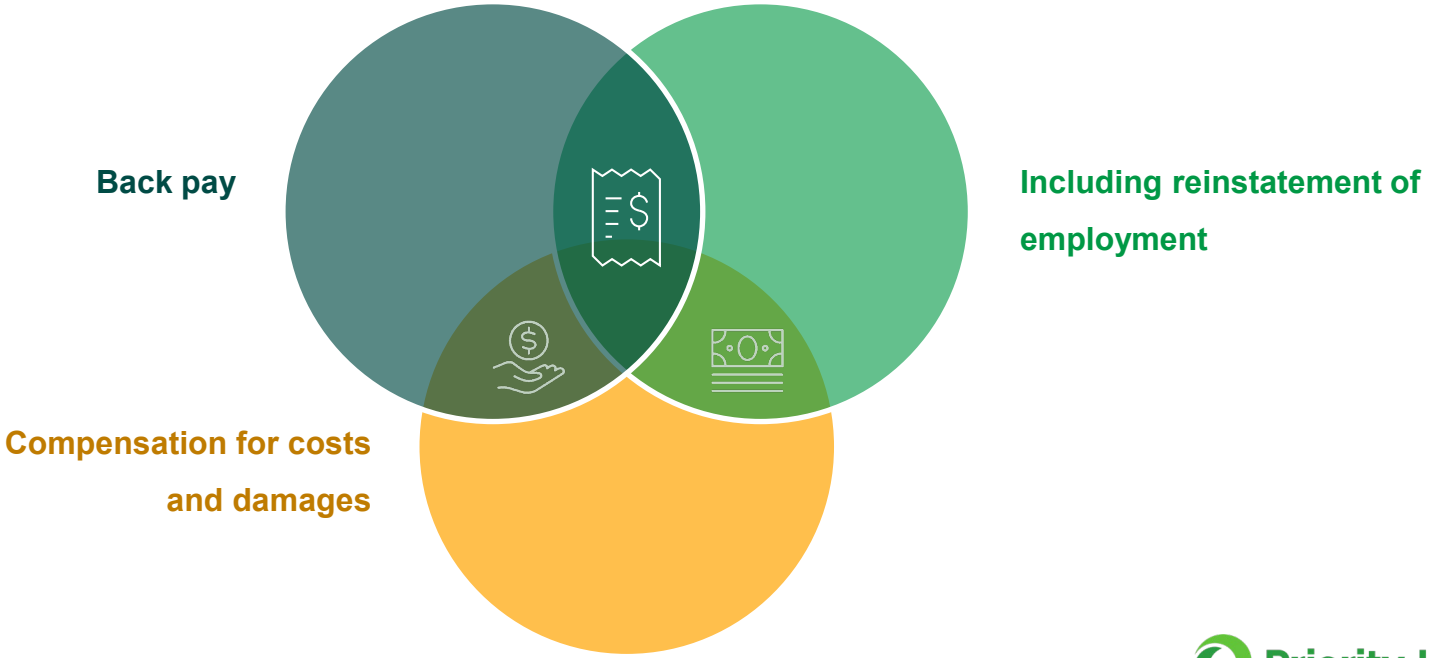
Whistleblower Provisions

Retaliation against someone who files a Fales Claim Act lawsuit, or tries to stop or prevent an FCA violation, may entitle the individual to additional relief;



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What to do about Retaliation

Priority Health prohibits retaliation directed toward a person who is involved in:

- Reporting potential issues or concerns
- Investigating issues
- Conducting self-evaluations
- Audits
- Remedial actions

Any individual who commits or condones any form of retaliation is subject to appropriate corrective action including termination of contract.

If you believe that retaliation has occurred report it to the compliance department.

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Beneficiary Inducement Law

The Beneficiary Inducement Law makes it illegal to offer remuneration that a person knows (or should know) is likely to influence a Medicare or Medicaid beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order, or specialty pharmacy. Because remuneration has a broad definition, there are certain legal exceptions.

Incentives offered to beneficiaries to join a health plan are not covered by the federal Beneficiary Inducement Law. However, inducements offered to beneficiaries to use a particular pharmacy are covered by this law.

Violations of the Beneficiary Inducement Law may result in civil monetary penalties of up to $10,000 for each wrongful act.

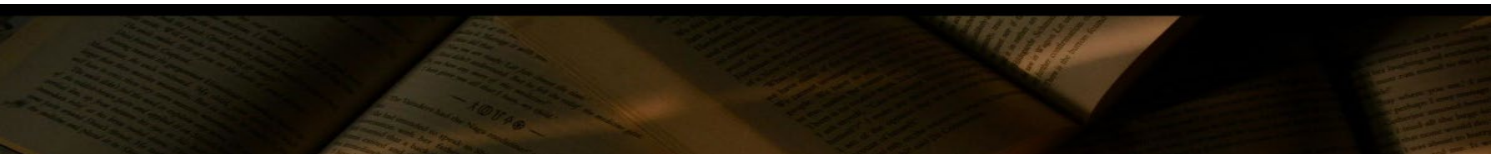
Beneficiary Inducement Law Exceptions

Exceptions to the Beneficiary Inducement Law include:

Properly disclosed differentials in a health insurance plan's copayments or deductibles. For example, plans may establish lower plan copayments for using preferred providers, mail order pharmacies, or generic drugs.

Certain incentives to promote the delivery of preventive care, as defined by regulation. These incentives may not be in the form of cash or cash equivalents and may not be disproportionate to the value of the preventive care provided.

Any practice permitted under an Anti-Kickback Statute safe harbor.



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Beneficiary Inducement Law Gift / Service Guidance

According to the OIG, beneficiaries **may** be offered inexpensive gifts or services.

Gifts are items such as refreshments or literature.

Services may be medical services such as blood pressure checks.

These gifts or services may not be in the form of cash or cash equivalents (certain gift cards, including Visa, Amazon, or Meijer and only permitted if it is redeemed for Food purchases) and may not have a retail value of more than $15 per gift, or $75 in the aggregate per beneficiary, annually. More expensive gifts or services are permitted if the item or service falls within one of the exceptions.

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Penalties for Fraud, Waste and Abuse

These are potential penalties for FWA though the actual consequence depends on the violation.

- Civil monetary penalties
- Criminal conviction/fines
- Civil prosecution
- Imprisonment
- Loss of provider license
- Exclusion from federal health care programs
- Debarment from government contracts

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Exclusions

State and federal agencies such as the MDHHS OIG, HHS, OIG, OPM OIG have the authority to exclude individuals and entities from participation in government health care programs. Exclusion means no payment will be made for items or services furnished, ordered or prescribed by an excluded individual or entity.

Reinstatement is not automatic. Providers must contact the exclusion agency to apply to have their name be removed.

Priority Health has adopted the state and federal exclusion process for all Priority Health products including our commercial programs.

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CMS Intermediate Sanctions

CMS may suspend enrollment for, and payment to, a Medicare health plan or Prescription Drug Plan (PDP) and may impose civil money penalties up to $25,000 for each violation.

Additionally, up to a $10,000 penalty can be fined if the health plan:

- Fails substantially to provide medically necessary items and services that are required to be provided to an enrollee and if the failure has harmed the individual.
- Imposes excessive premiums on enrollees.
- Inappropriately expels or refuses to re-enroll an individual.
- Engages in any discriminatory enrollment and disenrollment practices.
- Misrepresents or falsifies information that is submitted to CMS, to an individual, or to any other entity.
- Employs or contracts with any individual or entity that is excluded from participation in the Medicare program.

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FWA in the Headlines

Former NBA players Davis and Bynum convicted in $5m insurance fraud

- Players submitted false claims to NBA's health plan
- Doctors and dentists were also implicated in scheme

Sources:
https://www.theguardian.com/sport/2023/nov/16/former-nba-players-davis-and-bynum-convicted-in-5m-insurance

https://www.cbsnews.com/news/nba-health-insurance-fraud-big-baby-glen-davis-will-bynum/

- Scheme involved 20 NBA players
- Players were convicted of bilking the basketball league's health care plan of millions of dollars while trying to recruit other players to join the scheme
- Conspired with a California dentist and a doctor in Washington state to submit fake medical and dental bills for reimbursement even though the services were not actually done
- Submitted 3.9M in false claims with $3.4M of that amount paid between June 2017 and December 2018

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FWA in the Headlines

United States Attorney's Office
Western District of Michigan

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PRESS RELEASE

Former West Michigan Doctor To Be Sentenced In October

Thursday, August 10, 2023

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For Immediate Release

U.S. Attorney's Office, Western District of Michigan

U.S. Attorney's Office Seeks to Identify Any Additional Victims of Dr. Daniel Castro

GRAND RAPIDS – On April 3, 2023, Daniel J. Castro, M.D., pled guilty to making a false statement related to health care matters in violation of Title 18, United States Code, Section 1035. The sentencing hearing for Dr. Castro is scheduled for October 5, 2023, at 9:00 a.m. at the United States District Court, 315 W. Allegan Street, Lansing, Michigan.

As part of the plea agreement, Dr. Castro agreed that conduct related to certain health care fraud schemes set forth in the Indictment against him would constitute relevant conduct for purposes of his sentencing. As alleged in the Indictment, Dr. Castro engaged in a scheme to defraud health care benefit programs by performing medically unnecessary sinus surgeries. Additionally, he engaged in a scheme to defraud by billing excisions of single lymph nodes, submandibular glands, and other glands of the neck as if he performed modified radical or selective neck dissections, which are complex and higher-paying procedures for cancer of the head and neck. These schemes to defraud are alleged to have occurred from February 2015 until May 2017 at Bronson Battle Creek Hospital.

Source:
https://www.justice.gov/usao-wdmi/pr/2023_0810_Daniel_Castro_Notice_of_Sentencing

Daniel J. Castro, MD
Bronson Battle Creek Hospital
(2015-2017)

- Performed medically
- Billed for more complex and higher-paying procedures
- Profited more than $750,000 through overbilling

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FWA in the Headlines

Some insurance brokers enroll people in ACA plans without consent

JANUARY 17, 2022 · 5:00 AM ET

FROM KFF Health News

By Julie Appleby

Some insurance brokers are enrolling people into Affordable Care Act health plans without their consent, perhaps for the commissions, a move that could put consumers in danger of owing back the subsidies connected with the coverage. The damage could be hundreds or even thousands of dollars.

A consumer's first hint that something is wrong is a big one: a letter from the IRS or a delay in their tax refund.

Source:
https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent

Priority Health

Special Investigations Unit (SIU)

Priority Health is committed to the detection, investigation and correction of potential FWA and has established the SIU to lead this effort.

The SIU team proactively addresses questionable activity and investigates referrals of potential FWA.

The SIU investigate all types of potential fraud including, provider, pharmacy, member, employer group and agent fraud.

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Our Anti-Fraud Program

Our SIU has developed a comprehensive FWA Plan. The plan is integral to our Compliance Program and applies to all lines of business including commercial plans, Medicare Advantage plans, Medicaid Advantage plans, Medicaid managed care plans, and D-SNP.

The FWA Plan is established and maintained to achieve the following objectives:

- Follow all applicable federal and state rules, laws, regulations and other requirements
- Detect and prevent future fraud, waste and abuse
- Facilitate the identification and investigation and investigation of fraud

The FWA Plan is reviewed at least annually and are revised as needed when laws or regulations change.

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Referral of Fraud, Waste or Abuse

When fraud, waste or abuse is suspected, the case should be referred to the SIU teams for investigation. If a case reveals significant fraud or abuse, the SIU teams will refer it to the appropriate agencies, including:

- Department of Justice, Assistant US Attorney, Federal Bureau of Investigation
- Department of Health & Human Services' Office of Inspector General
- State prosecutors and police
- Regional task force

- Department of Insurance and Financial Services
- State medical or other professional licensing boards
- NBI MEDIC
- State OIG
- OPM OIG

Convicted persons may be required to pay back the stolen money and may face additional fines or imprisonment.

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Detecting Fraud, Waste, Abuse

In addition to referrals, the following are in place to help us detect potential FWA:

Annual FWA risk assessment is conducted in order to identify areas of concern for potential FWA.

Audits and data analysis – The proactive review of claims data and an analysis of the information for irregularities might indicate fraud or abuse. In many cases, suspect claims have already been processed and paid but if there is an indication of something wrong in our review, we can use that evidence to help get our money back.

Computer applications – Computer applications can be used to electronically identify fraudulent health care claims. These applications can extract data from our data warehouse and crunch the numbers to identify billing patterns and trends that may indicate fraud, abuse, or erroneous charges received from providers and subscribers / members.

Partnership with Pharmacy Benefit Managers (PBM) to obtain valuable leads identifying potential FWA in pharmacy claims.

Participation in several workgroups including MDHHS OIG Program Integrity Group, CMS Fraud Working Group, and the NHCAA Focus Group.

Responses to Fraud or Abuse Investigations

Education

If it is determined that abuse occurred through a misunderstanding of billing or coverage guidelines and no fraud was involved, the problem may be corrected through education. The steps in this process are:

- Identify the problem
- Educate the provider

- Recover overpayment
- Re-audit the provider

Termination

In addition to criminal or civil proceedings, Priority Health will end its relationship with those who commit fraud. Plans reserve the right to revoke membership for subscribers / members who commit fraud and may cancel contracts with providers, brokers, and others who violate their agreements. In some cases, Priority Health may refer fraudulent providers to medical boards for investigation and license revocation.

Civil Proceedings

Health plans may choose to file civil lawsuits in response to cases of fraud or abuse. Depending on the situation, violators may face both *criminal* and *civil* proceedings. Either way, Priority Health will seek payment for the stolen amount.

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How Do I Prevent FWA?

- Make sure you are up to date with laws, regulations and policies
- Fix processes that are deficient or prone to error
- Fix potential issues before they become problems
- Ensure data is both accurate and timely
- Verify information provided to you
- Be on the lookout for suspicious activity and report it
- Assist in promoting a culture of compliance

Detection of FWA

Detection is a key component of fighting FWA and you play an important role. Since you work closely with claims, speak with members and providers, and scrutinize data – you could easily account for a significant number of tips on potential FWA. **You** are our not-so-secret weapon when it comes to detecting cases of fraud and abuse.

Be on the lookout for suspicious activities and report your concerns.

Provider

Member

Pharmacy

Telemedicine

Priority Health

Examples of Suspicious Activity

Provider FWA Key Indicators

- Submitting bills or claims for treatment or services that were never provided. These situations are usually identified when subscribers / health plan members question payment reflected on their Explanation of Benefits (EOBs).
- Falsifying the date of service to correspond with a member's coverage period.
- Diagnose a different or more serious illness to obtain payment for more expensive treatment or equipment.
- Billing for non-covered services using incorrect codes to have the services covered.
- Submitting separate charges for procedures that are all part of the same procedure (known as unbundling).
- Providing unnecessary procedures or prescribing unnecessary drugs.
- Altering medical records to obtain a higher payment amount.
- Misrepresenting who rendered the service – such as billing for an office visit when the only service were an injection by a medical assistant.
- Soliciting, offering or receiving a kickback in exchange for a referrals of patients.

*These are only some examples of potential FWA

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Examples of Suspicious Activity

Member FWA Key Indicators

- Using someone else's identity in order to receive insurance benefits like prescriptions, services, equipment, supplies, doctor visits and / or hospital stays.
- Adding ineligible departments to their policy (ex. over-age dependents; ex-spouses).
- Submitting false claims for reimbursement by forging bills or claim forms in the hopes of pocketing the cash.
- Concealing information about additional coverage in order to lower out-of-pocket payments or receiving inappropriate reimbursement from multiple plans.
- Doctor shopping – multiple providers are seen to obtain multiple prescriptions for controlled substances.
- Resale of drugs on the black market, falsely reporting loss or theft of drugs.
- Falsifying or modifying a prescription.
- Misuse of benefits (ex. repeatedly visiting an emergency room for non-emergency illness).

*These are only some examples of potential FWA

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Examples of Suspicious Activity

Pharmacy FWA Key Indicators

- Inappropriate pharmacy billing: billing for medication that was never dispensed; billing for brand name drugs, but dispensing generics.
- **Prescription drug shorting: intentionally providing less than the prescribed quantity and not informing the patient.**
- Prescription forging or altering: increasing the quantity of tablets or number of refills without the provider's permission; substituting more expensive brand name drugs in place of generic drugs.

*These are only some examples of potential FWA

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Examples of Suspicious Activity

Telemedicine FWA Key Indicators

- Telemedicine FWA can take a variety of different forms ranging from false claims stemming from inaccurate billing and coding to complex kickback schemes.
- Upcoding time and complexity: provider inflating time spent rendering telemedicine service to increase reimbursement.
- Misrepresenting the virtual service provided: billing for a virtual visit when provider conducted a telephone consult.
- Billing for services not rendered: provider submitting claims for services not provided or provided effectively. Even if a provider attempts to provide services in good faith, but technical difficulties prevent them from doing so, services should not be billed. (Ex. telemedicine appointment occurs but the patient clearly cannot fully see or hear or otherwise benefit from the appointment).

*These are only some examples of potential FWA

Priority Health

Your Role in the Fight Against FWA

You play a vital role in preventing, detecting and reporting potential FWA.

1. You have a duty to follow the Priority Health Code of Excellence which articulates our commitment to ethics and integrity.

2. You are required to comply with all applicable statutory and regulatory requirements that govern our business.

3. You have a duty to report any compliance concerns and suspected or actual violations that you may be aware of.

https://www.priorityhealth.com/contact-us/reporting-fraud-and-abuse/reporting-fraud

Priority Health

03

Privacy / Information Security

Priority Health

What is HIPAA and the Privacy Rule?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the US Department of Health and Human Services to develop regulations protecting the privacy and security of certain health information.

There are two rules for HIPAA: the **HIPAA Privacy Rule** and the **HIPAA Security Rule**.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other Protected Health Information (PHI) and applies to covered entities*. Protected data also includes Personally Identifiable Information (PII).

It requires safeguards to protect the privacy of PHI and controls use and disclosures that can be made without patient authorization. Also, it gives patients certain rights to their health information.

*Covered entities are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which Health and Human Services (HHA) has adopted standards.

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Protected Health Information

PHI is any information **created, received** or **stored** by a **covered entity*** (such as Priority Health), including demographic data, that relates to:

The individual's past, present, or future physical or mental health condition;

The provision of health care to the individual; or

The past, present, or future payment for the provision of health care to the individual;

AND

That identifies the individual or for which there is a reasonable basis to believe that information can be used to identify the individual.

HIPAA Privacy Rule protects PHI for 50 years following the date of death of a patient – team and family members still need required authorization.

*Covered entities are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which Health and Human Services (HHA) has adopted standards.

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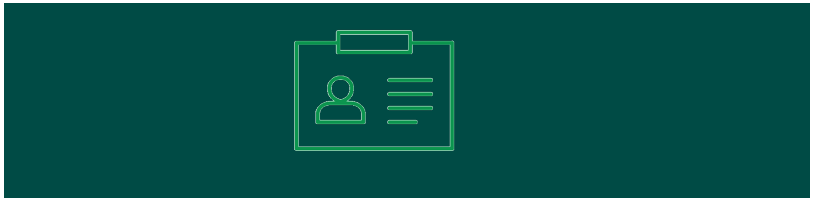
What are the 18 Patient Identifiers?



1. Names
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death
4. Phone numbers
5. Fax numbers
6. Electronic mail addresses
7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers

10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers
13. Device identifiers and serial numbers
14. Web Universal Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

It is recommended to use **at least 3 patient identifiers** to identify patients

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Minimum Necessary

We must make every reasonable effort to limit use, access and/or disclosure of PHI to the minimum information necessary to accomplish a task for your job.

- ✓ Follow minimum necessary requirements
- ✓ Pay attention to avoid mistakes
- ✓ Report and mitigate all mistakes with PHI
- ✓ Unauthorized accessing of PHI or medical plan information could **result in** corrective action including termination of contract.

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Permitted uses for PHI

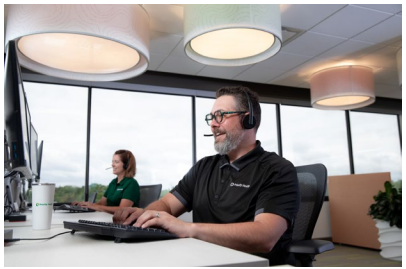
Under HIPAA, patient authorization is not needed to use PHI for TPO purposes:

Treatment

The provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another

Payment

Billing, coding, claims management, insurance payments, collection and related health care data processing



Health Care Operations

Quality and process improvement activities, re-certification, system auditing functions and underwriting and other activities related to the contracting of health insurance or benefits

Additional written authorization must be obtained from a patient for all uses and disclosures of PHI other than for Treatment, Payment or Health Care Operations (TPO). **The following items are NOT covered under TPO:**

Marketing | Research | Uses not otherwise permitted | Release of Information

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Confidentiality

Patients expect that their confidentiality is maintained, and this is enforced by HIPAA.

When accessing patient information, be sure you are only using the minimum necessarily needed to complete your job functions.

Never access your own information (access only through MyChart)

Never access the records of friends or family for reasons outside of Treatment, Payment, or Health Care Operations (TPO) purposes. Curiosity and caring are not acceptable reasons to access a patient record. If you are not the care provider for an individual, do not access their information. It is recommended you recuse yourself from working with family members when possible.

Discussing or sharing patient information outside of TPO purposes is a violation of HIPAA and policy. This also includes social media. Never share any information gained through your relationship with the patient on social media. Even in the case of de-identified information, comments from you or your colleagues may lead to inadvertent identification of the individual making the post a breach of privacy.

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HIPAA Security Rule

The **HIPAA Security Rule** requires we maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic-PHI (e-PHI).

Specifically, we must:

- Ensure the confidentially, integrity, and availability of all e-PHI we create, receive, maintain or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the information;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by the workforce.

All individuals are required to ensure that day-to-day operations and interactions with digital systems are secure.

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Guidelines for Use of Social Media

If you are going to use social media, the following recommendations may be helpful.

1. **Never share PHI / health plan member information** on social media. Even de-identified information or images can be considered PHI if accompanied with other data that could be used to identify an individual.

2. **Do not share photographs/videos** of patients or health plan members without proper authorization or consent forms.

3. **Do not share, post** or otherwise publish any information, including **images** or **recordings**, that you have **obtained as a result of your professional relationship** with a patient or health plan member.

4. **Do not interact with any posts** the patient or health plan member makes **about the medical conditions they have.**

5. **It is not recommended to friend** or follow **patients or health plan members** on social media sites.

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Secure your Workspace

Physical access is the quickest way for someone to get information.

- Do not leave computers / patient files / sensitive data unlocked (Log out with Windows Key + L OR approved department logout procedures) **even when working from home**
- Securely store personal devices or carry them on you
- Properly store or dispose of all papers in a secure manner
- Be aware and suspicious of unknown individuals in secure areas
- Create strong passwords, don't share or reuse them
- It is a violation of policy to share passwords with anyone

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Protecting Sensitive Data

To avoid sending PHI to unauthorized individuals, please consider these tips:

- **Encrypt:** If sending a request for sensitive information (outside of Priority Health) your email must be encrypted. PHI or PII cannot be included in a subject line.
- **Review before Sharing:** Be sure any attachments or content in an email is necessary for all recipients before forwarding.
- **Check for Minimum Necessary:** Limit PHI and PII to what is necessary to complete the job function and only include those who need to know, especially when forwarding.

Storing Sensitive Data

Do not store sensitive data on unapproved cloud services, public network drives or unapproved devices (e.g. personal devices).

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Phishing Threats

The term ‘phishing‘ is taken from the word ‘fishing.’

Much like fishing, ‘phishing’ is when cyber criminals try to lure people into clicking a link or opening an attachment in an email that will either download malware or steal sensitive data.

Signs of a Phishing Email:

- Impersonal greeting
- Unrecognized senders email
- Unsolicited link/file
- Punishment/fear/urgency
- Poor grammar
- Promoting offers or solutions for current local, national or global issues

What do phishers want?

- Bank information
- Credit card information
- Usernames and emails
- Passwords
- Personal information
- Medical records
- Access to other team members or executives
- Health plan data
- Company financial records

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Privacy and Information Security Contacts

Privacy Team: privacy@corewellhealth.org

Privacy Hotline: 616-486-4113

Compliance Help Line: 800.560.7013

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