## 5.1 a Claims Submission Procedures

### Submitting Claims Electronically

Senior Health Partners uses the Change Healthcare clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 and UB 04 receive a status report indicating which claims were accepted, which were rejected, and/or which are pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

1. Senior Health Partners' Payer ID Number 80141
2. Complete Senior Health Partners Member's CIN ID number
3. A National Provider Identifier (NPI) should reside in:
    - 837 Professional (CMS)-Loop 2310B Rendering Provider Secondary ID, Segment/Element NM109. NM 108 must qualify with an XX (NPI)
    - 837 Institutional (UB04)-Loop 201 AA Billing Provider, Segment/Element NM 109. NM 108 must qualify with an XX (NPI)

To sign up for electronic billing, providers must contact their software vendor and request that their Senior Health Partners claims be submitted through Change Healthcare. Providers can also direct their current clearinghouse to forward claims to Change Healthcare. Please contact Change Healthcare at 1-800-845-6592 for information on how to set up electronic billing.

If you have any questions regarding claims issues, please call 1-877-737-2693. Representatives are available Monday to Friday, 9am–5pm.

### Submitting Paper Claims

All paper claims should be submitted to:

**Senior Health Partners Claim Department**
**P.O. Box 958439**
**Lake Mary, FL 32795-8439**

All paper claims should include the National Provider Identifier (NPI) as well as the Senior Health Partners-assigned Provider ID Number (the latter is not required for electronic claims). The Senior Health Partners Provider ID is a unique provider number for each practice site.

### Timely Claim Submission

In-network providers must file claims within 180 days of the date of service. Out-of-network providers must file claims according to Medicare fee-for-service rules.

Authorizations: All Senior Health Partners network providers and out-of-network providers will receive an authorization for covered services EXCEPT FOR dentistry, optometry, audiology, and podiatry. Except for emergency services and treatment of urgent medical conditions, providers are required to obtain authorizations prior to providing services to Senior Health Partners members, whether or not a Senior Health Partners provider referred the member. Contact Senior Health Partners' Care Management Team at 1-212-324-2600 for questions related to care management and service authorizations.

### Billing Senior Health Partners

All payments for services provided to Senior Health Partners members constitute payment in full. **Providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts; any such billing is a violation of the provider's contract with Senior Health Partners and of applicable New York State Law.** Where appropriate, Senior Health Partners will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Reference: Tab 3 – Sample Blank HCFA Form 1500

## 5.1b Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Senior Health Partners regarding a claim determination. Some of the common reasons include, but are not limited to, incorrectly processed or denied claim, the untimely submission of claims, or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Senior Health Partners must submit a **written** request for review and reconsideration with all supporting documentation to Senior Health Partners within **90 (ninety) calendar days** from paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, must be mailed to the following location:

**Senior Health Partners Claims Department**
**P.O. Box 958439**
**Lake Mary, FL 32795-8439**

All written requests for Review and Reconsideration should include the following information: a copy of the EOP, the claim, any supporting documentation, and a written statement explaining why you disagree with Senior Health Partners' determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with a written request for review and reconsideration include:

- A written statement explaining why you disagree with Senior Health Partners' claim determination
- Provider's name, address, and telephone number
- Provider's identification number
- Member's name and Senior Health Partners identification number
- Date(s) of service
- Senior Health Partners claim number
- A copy of the original claim or corrected claim, if applicable
- A copy of the Senior Health Partners EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g., copy of Senior Health Partners Member ID card)
- Evidence of timely filing
    - R059/RPT-11 Report (insurance Carrier Rejection report) or Change Healthcare Vision "Claim for Review" / "Claim Summary Report
    - Please note: Senior Health Partners **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing
- Copy of the approval number issued by the Care Management Team

Senior Health Partners will investigate all written requests for Review and Reconsideration and issue a written explanation—stating that the claim has been either reprocessed or the initial denial has been upheld—within 30 (thirty) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

**Senior Health Partners will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the 90 (ninety) calendar day timeframe, the request is deemed ineligible and will be denied. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.**

All questions concerning requests for review and reconsideration should be directed to the Provider Services

unit at **1-877-737-2693**.

# 5.3 Fraud Waste and Abuse

It is the policy of Healthfirst to comply with all federal and state laws regarding fraud, waste, and abuse, to implement and enforce procedures to detect and prevent fraud, waste, and abuse regarding claims submitted to federal and state healthcare programs, and to provide protection for those who report in good faith actual or suspected wrongdoing. Healthfirst is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the NY state-funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

## 5.4 The Compliance Policy

Healthfirst maintains a strict policy of ***zero tolerance*** toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, Healthfirst provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

In general, Healthfirst has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or Healthfirst from paying more for a service than it is obligated to pay. Therefore, Healthfirst established a Special Investigations Unit (SIU), which ensures that Healthfirst is in compliance with all applicable state and federal regulations.

**The SIU**

The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if fraud or abuse has occurred. Therefore, Healthfirst employees and contracted entities have a responsibility to report any inappropriate activities to the SIU and the Regulatory Affairs department or their immediate supervisor, if applicable.

For further information on our compliance program, please visit our provider web page at www.healthfirst.org and select *"A Guide to the Compliance Program."*

## 5.4a Definitions

**Abuse—**Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

**Fraud—**An intentional deception or misrepresentation made by a provider, person, or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

**Waste—**The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

# Relevant Statutes and Regulations

**Stark Law**

The Stark Law, with several separate provisions, governs physician self-referral for Medicare and Medicaid

patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship—unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral. Violations of the Stark Law and Physician Self-Referral are to be reported to the Centers for Medicare and Medicaid Services through an established self-disclosure process.

**Anti-Kickback Statute**

The Medicare and Medicaid Patient Protection Act of 1987 provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other federally funded or State-funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital, and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

**False Claims Act**

**31 U.S.C. §§ 3729–3733**

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, “knowing and/or knowingly” means that a person has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Healthfirst
- Knowingly failing to provide members with access to services for which Healthfirst has received premium payments
- Knowingly submitting inaccurate, misleading, or incomplete Medicaid cost reports

**False Claims Act Penalties**

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $10,957 and $21,916) for every false claim, and the claimant's costs and attorneys' fees, as adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1). If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds.

**Protections for Whistleblowers**

Whistleblower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending, or harassing the whistleblower. If an employer retaliates in anyway, whistleblower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

To report information about fraud, waste, or abuse involving Medicare or any other healthcare program involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is 1-800-HHS-TIPS (1-800-447-8477). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

The following are the applicable False Claims Act regulations, for reference:

**Federal False Claims Act Civil Remedies Act**

**31 U.S.C. 3801-3812**

**For a copy of this citation, please visit** https://federalregister.gov/a/E9-12170.

This act provides federal administrative remedies for false claims and statements, including those made to federally funded healthcare programs. As of August 1, 2016, False Claims Act civil penalties increase to between $10,781 and $21,563 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. It is important to note that when False Claims Act penalties increase, so do the financial rewards for whistleblowers, increasing their incentive to allege false or fraudulent claims. The amount of the false claims penalty is adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1).

**For a copy of the New York citations listed below, visit** the Law of New York website at http://public.leginfo.state.ny.us/menugetf.CGI?COMMONQUERY=laws.

**NY False Claims Act (State Finance Law, §§187-194)**

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $10,781 to $21,563 per claim, and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government's legal fees.

The FCA allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25% to 30% of the proceeds if the government does not participate in the suit and 15% to 25% if the government participates in the suit.

**Social Services Law §145-b False Statements**

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment, or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five years, a penalty of up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

**Social Services Law §145-c Sanctions**

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's family's needs are not taken into account for six months if a first offense, 12 months if a second (or once if benefits received are over $3,900), and five (5) years for four or more offenses.

**Social Services Law §145 Penalties**

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

**Social Services Law § 366-b, Penalties for Fraudulent Practices**

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation, or other fraudulent means is guilty of a Class A misdemeanor. Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation, or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

**Special Investigations Unit**

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste, and abuse awareness, detection, investigation, and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention, and reporting.

**Healthfirst-Contracted Vendor**

Healthfirst contracts with a vendor to assist in the identification of potential fraud, waste, and abusive billing practices as mandated by federal and state regulations. Through the use of state-of-the-art detection software, this vendor identifies billing patterns that are not within industry norms. Providers selected for review will be asked to submit medical records for examination. Please note that it is important to provide the Healthfirst contracted vendor with all requested supporting documentation upon request. This will minimize any future disputes regarding any identified issues. Failure by a provider to provide the requested records within 30 (thirty) calendar days of a request or to send the requested records to the address indicated in the record request letter will result in the denial of payment and/or recoupment of previously paid claims.

If, after a complete review of all documentation provided, it is believed that the services billed are unsupported, they will be considered overpayments and Healthfirst will utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. If appropriate, education will be provided to ensure further billings are submitted according to established guidelines. The results of these reviews are presented to the Healthfirst Fraud, Waste and Abuse Committee. Failure to cooperate may result in the non-renewal or termination of your contract with Healthfirst and/or additional reporting to state and/or federal authorities.

**Fraud, Waste, and Abuse Committee**

The Fraud, Waste and Abuse Review Committee (FWAC) is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers. The committee has the authority to make determinations and/or recommendations to the Healthfirst Credentialing Subcommittee regarding allegations including, but not limited to, placement of a provider on prepayment review, termination of the provider agreement according to the guidelines described in Section 3.8, referral of the provider to the applicable regulatory or law enforcement agencies, and recovery of overpayments.

Upon referral by the FWAC, the Credentialing Subcommittee will conduct a separate review of the allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. The Credentialing Subcommittee will render the final decision as to whether a provider should be terminated. Except in instances of immediate termination, when termination is recommended, a Notice of Proposed Adverse Action will be issued to the provider, and the provider shall have the opportunity to appeal the decision, as outlined in Section 3.8.

The Fraud, Waste and Abuse Committee meets approximately 15 (fifteen) times during the year and comprises the following Healthfirst staff members:

- Vice President, Deputy General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President, Claims
- Vice President, Regulatory Affairs
- Vice President, Compliance and Audit
- Vice President, Network Management
- Director, Special Investigations Unit

**Prepayment Review**

As part of its fraud, waste, and abuse prevention and detection program, Healthfirst maintains a prepayment review program (PPR) in which providers must submit records to support the claims billed prior to payment being issued. After a provider is placed on PPR via the below detailed procedures, no claim will be paid unless medical records (1) are submitted timely; (2) are submitted to Healthfirst at the address indicated in the record request letter; and (3) support the services billed, including, but not limited to, the medical necessity and the level of services billed.

Where the FWAC determines that a provider should be placed on PPR due to identification or reasonable suspicion of fraud, waste, or abuse, Healthfirst's vendor administrator (the "Vendor") will notify the provider of the FWAC's decision and that the provider will be on PPR for a period of at least six months. The FWAC

will review the provider after at least each six-month period that a provider is on PPR to determine if the provider has changed their behavior, is maintaining the required documentation, and, where applicable, has resolved any overpayment requests. The Vendor will also send a request(s) for medical records to the provider for all subsequently submitted claims to ensure that claims submitted for payment are supported by appropriate documentation meeting all applicable laws, rules, and regulations; coding; and contractual requirements. Providers will have a period of 30 days to submit requested records. In the event records are not submitted within 30 days of the request, the claims at issue will be denied. Records received after the 30-day deadline will not be considered.

All records must be sent to the address listed in the PPR medical record request letter from the Vendor. Records sent to any other address will not be considered. The submitted medical records will be reviewed to determine if the claim lines billed by the provider are supported by appropriate documentation. If the records support the claim (e.g., that the services billed were rendered, were medically necessary, and were appropriately performed and documented, etc.), the claim will be approved for payment. The provider should submit all necessary information and records, including, but not limited to, records to indicate that the services were rendered, all test results, records to indicate an ongoing course of treatment, evidence of a referral, etc. If the documents are not supportive of the services billed, the claim will be denied. Claim lines with no records—either because the provider failed to maintain such records or failed to provide such requested records—will be denied for payment. Providers will be informed of the PPR decisions through the provider portal or an explanation of payment.

If providers disagree with the PPR claim determination, they may submit a review and reconsideration (e.g., first-level appeal) within 90 (ninety) calendar days of the claim decision. Providers must submit additional supporting documentation directly to the Vendor at the address listed in the PPR medical record request letter for reconsideration and review in a timely manner. Thereafter, if a provider disagrees with the decision on review and reconsideration, a further appeal is available pursuant to the “Claims Appeal Process” detailed in Section 17.6 of the Provider Manual. All appeals must be submitted to Healthfirst at the address indicated in Section 17.6 of the Provider Manual and must include a cover letter noting that this is an appeal from a PPR determination. The review and reconsideration and the appeal processes shall otherwise be conducted in accordance with Section 17.6 of the Provider Manual.

## Retrospective or Post-Payment Review

Periodically, the Vendor and the SIU conduct audits of claims that have previously been paid by Healthfirst. In such audits, the Vendor or the SIU will request documentation from providers which is required to be maintained in accordance with applicable laws, rules, and regulations; coding requirements; and contractual requirements. The Vendor then presents the audit outcome to the provider in an Audit Findings Report (AFR). If the provider disagrees with the findings in the AFR, the provider must follow the review and reconsideration and appeal processes noted in the above “Prepayment Review” Section. If a timely request for review and reconsideration or appeal is not initiated by the provider, the determination of the AFR will be deemed final and sent for overpayment recovery in accordance with Section 5.5 of this Provider Manual and any other available means of recovery (e.g., collections agency, litigation, etc.). Most retrospective reviews are based on a statistically valid sample; however, in some instances, audits may be conducted based on specific ICD 9/10 code issues.

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste, and abuse awareness, detection, investigation, and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention, and reporting.

**Prescription FWA – Premier Audit Meetings**

In addition to the Fraud, Waste and Abuse Committee’s work discussed above, Healthfirst also conducts quarterly Premier Prescription FWA Audit meetings. This committee is concerned with fraud, waste, and abuse and potentially hazardous prescription use within the Prescription Drug Program. The committee meets to review reports prepared by CVS Caremark, the plan’s contracted Pharmacy Benefit Manager. The committee is responsible for directing all further investigative activities and reporting of suspect, questionable activities to the plan’s Fraud, Waste and Abuse Committee for further direction.

The committee is composed of the following Healthfirst staff members:

- Vice President, Pharmacy
- Pharmacy Director or pharmacist alternate
- Director, Special Investigations Unit
- Supervisor, Special Investigations Unit
- CVS Caremark Representatives

**Restricted Recipient Program**

Restricted Recipient Program (RRP) is a program whereby selected enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more RRP providers for receipt of medically necessary services. Restricted Enrollee means an enrollee who has engaged in abusive practices or demonstrated a pattern of misuse of a category of Medicaid or FHP benefits and has been restricted by either the contractor or OMIG to receive certain services only from an assigned RRP provider. The amount, duration, and scope of the Medicaid or FHP benefit are not otherwise reduced.

**Member Review and Restriction Committee (MRRC)**

The Member Review and Restriction Committee oversees the Restricted Recipient Program (RRP), which is intended to reduce the cost of inappropriate utilization of covered services by identifying and managing enrollees exhibiting abusive or fraudulent behavior. Through increased coordination of medical services, the number of providers that the enrollee may select for care and the referrals to services, medications, and equipment is controlled; enrollees targeted for the Restricted Recipient Program are ensured access to medically necessary, quality healthcare, and unnecessary costs to the Medicaid program are prevented.

The MRRC is a professional team comprising, at a minimum, a physician, a registered professional nurse, and a pharmacist. The MRRC shall review and determine whether the enrollee has demonstrated a pattern of overuse, underuse, or misuse of services included in the Benefit Package and whether such behavior should be managed by the Restricted Recipient Program. The MRRC is also responsible for ensuring that the directives of the team regarding placing restriction of recipients are carried out. The MMRC consists of the following staff members:

- Vice President, Associate General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President, Claims
- Vice President, Regulatory Affairs
- Vice President, Compliance and Audit
- Vice President, Network Management
- Pharmacy Director or pharmacist alternate
- Director, Special Investigations Unit

**Common Methods of Fraud and Abuse**

In order to assist you with understanding and/or identifying what may constitute fraud, waste, and/or abuse, we have provided some typical examples for your reference.

**Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate member names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered
- A provider who, using existing information on his or her members, creates claims for office visits or services that never took place
- A provider who, in the course of billing for actual member treatments, adds charges for X-rays or laboratory tests that were never performed
- A durable medical equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up

**Falsification of Claims:** In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so
- A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery

- A provider falsifies the dates on which services were provided so that they fall within a given eligibility period of the member
- A provider falsifies the identity of the provider of services so as to obtain payment for services rendered by a noncovered and/or nonlicensed provider (e.g., submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy)
- A provider upcodes the services rendered to obtain greater reimbursement
- Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision-making than was actually rendered; encounters that required straightforward decision-making are reported as having required highly complex decision-making
- Reporting more intensive surgical procedures than were actually performed
- Anesthesiologist bill for more intensive surgical procedures than reported by the surgeon

**Unbundling:** Provider submits a claim reporting comprehensive procedure code (Resection of small intestine) along with multiple incidental procedure codes (Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

**Fragmentation:** Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

**Duplicate Claim Submissions:** Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

**Fictitious Providers:** Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

**Examples of FWA within the Prescription Drug Program**

**Plan Sponsor**

- Failure to provide medically necessary services
- Marketing schemes offering beneficiaries inducements to enroll
- Unsolicited marketing
- Misrepresenting prescription drug products
- Payment for excluded drugs
- Multiple billing
- Inaccurate data submission

**Pharmacy Benefit Manager (PBM)**

- Prescription drug switching
- Steering a beneficiary to a certain plan or drug
- Inappropriate formulary decisions
- Failure to offer negotiated prices

**Pharmacy**

- Inappropriate billing practices
- Prescription drug shorting
- Bait-and-switch pricing
- Prescription drug forging or altering
- Payment for excluded drugs
- Dispensing expired or adulterated drugs
- Prescription refill errors
- Failure to offer negotiated prices

**Prescriber**

- Prescription drug switching
- “Script” mills
- Provision of false information
- Theft of DEA number or prescription pad

**Wholesaler**

- Counterfeit or adulterated drugs through black markets
- Drug diversions
- Inappropriate/false documentation of pricing information

**Manufacturer**

- Lack of data integrity to establish payment or determine reimbursement
- Kickbacks, inducement, or other illegal remuneration
- Inappropriate relations with formulary committee members
- Inappropriate relations with providers
- Illegal “off-label” promotion
- Illegal use of free samples

**Beneficiary**

- Misrepresentation of enrollment status
- Identity theft
- Prescription forging or altering
- Drug diversion or inappropriate use
- Prescription stockpiling
- “Doctor shopping” for drugs

**FDR and Affiliates Compliance Requirements**

Healthfirst's commitment to compliance includes ensuring that our First Tier, Downstream and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. Healthfirst contracts with these entities to provide administrative and healthcare services to our enrollees; we are ultimately responsible for fulfilling the terms and conditions of our contract with the Centers for Medicare and Medicaid Services (CMS) and meeting the Medicare and Medicaid program requirements. Therefore, Healthfirst requires each FDR and Affiliate to comply with the compliance and fraud, waste, and abuse expectations.

Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with Healthfirst.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with Healthfirst policy and applicable Federal and State statutes and regulations. A copy of the Healthfirst compliance attestation and the FDR and Affiliate Compliance Guide can be found at www.healthfirstfdr.org.

**Reporting of Fraudulent, Wasteful, and Abusive Activities**

Healthfirst wants to make sure that our providers understand that we expect members, vendors, providers, interns (volunteers), consultants, Board members, and First Tier, Downstream and Related Entities (FDRs) as well as others associated with the business of Healthfirst to bring any alleged inappropriate activity that involves Healthfirst to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

**Healthfirst Compliance Officer at**:

Special Investigations Unit (SIU) at:
100 Church Street, New York, NY 10007
By phone – 1-212-453-4495

By phone – 1-212-801-3292

# 5.7 Provider External Appeals – Effective January 1, 2010

**Provider External Appeal Rights**

Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. A provider will be responsible for the full cost of an external appeal for a concurrent adverse determination upheld in favor of Senior Health Partners; Senior Health Partners is responsible for the full cost of an appeal that is overturned; and the provider and Senior Health Partners must

evenly divide the cost of a concurrent adverse determination that is overturned in part.

The fee requirements do not apply to providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application (see Attached External Appeals Application and Instructions) and the standard designation forms delivered by the State. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

**Hold Harmless**

Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member's designee, is prohibited from seeking payment, except applicable copays, from a member for services determined to be not medically necessary by the external appeal agent. Thus, members are held harmless in such cases.

## New York State External Appeal Application

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan's final adverse determination. For help call 1-800-400-8882.

1. **Applicant Name:**

_____

**(Please check one)** [ ]Insured/Patient [ ]Patient's Designee [ ]Provider

2. **Patient Name:**

_____

**3. Patient Address:**

_____

_____

4. **Patient Phone Number:**

**Home(_____)_____Work(_____)_____**

5. **Patient E-mail (if you want contact by e-mail):** _____

6. **Health Plan Name:**

_____

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination?

Yes _____ No_____

8. **Reason for Health Plan Denial: (Please check one.)**

[ ] Not medically necessary. [ ] Experimental / investigational.

[ ] Clinical trial. [ ] The treatment is for a rare disease.

[ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. **Attach the final adverse determination from the first level of appeal with the health plan, or the health plan's letter waiving the appeal,** along with any other information you would like considered.

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

10. If the patient has not received the service, the appeal may be expedited if the patient's physician fills out the attached form stating a delay will seriously threaten the patient's health. An expedited decision will be made in 3 days instead of 30 days, even if the patient or the patient's physician do not provide needed medical information to the external appeal agent.

**Is this a request for an expedited appeal?** [ ] Yes No [ ]

11. If this is a request for an **expedited appeal,** an appeal of **experimental / investigational services**, a **clinical trial denial**, an **out-of-network denial**, or a **rare disease treatment,** the patient must give the attached Physician Attestation (pages 3-5) to the physician who prescribed the treatment. (See special rules for rare diseases on page 3.) The physician must complete the form and send it to the Insurance Department. (Please check one.)

[ ] I gave the form to my physician [ ] I did not give the form to my physician.

12. **External Appeal Fee:** You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)

[ ] I enclosed a check or money order made out to the health plan.

[ ] I faxed my application and will mail the fee to the Insurance Department within 3 days.

[ ] The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.

[ ] The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.

[ ] The health plan does not charge a fee for an external appeal / the fee is not required.

13. **I am sending this application to the Insurance Department by:** (Please check one.)

[ ] Certified or registered mail to New York State Insurance Department, PO Box 7209, Albany, NY 12224-0209.

[ ] Fax to **1-800-332-2729.** If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

14. **Name of the Patient's Physician / Provider:** _____

**Address:** _____
_____

**Phone Number:** (_____)_____

**Fax Number:** (_____)_____

15. **Complete this only if a designee submits this external appeal on the patient's behalf.** The patient is under no obligation to request an appeal and may be asked to confirm that a designee was authorized.

**Name of Designee:** _____

**Relationship to Patient:** _____

**Address:** _____

**Phone Number: (_____)**_____

**Fax Number: (_____)**_____

**Designee E-mail (if you want contact by e-mail):** _____

16. The patient must sign and date this external appeal request and consent to the release of medical records. An external appeal agent assigned by the New York State Insurance Department will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I, _____ hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related, mental health, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on my appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Insurance Department in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

_____

**Signature of Patient**

_____

**(Date)**

(Or the patient's representative who can consent to the release of the patient's medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

**Patient's Health Plan ID#:**_____

17. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. **This item should only be completed by providers appealing on their own behalf, or as**

**the patient's designee.** The health plan's initial denial and final adverse determination from the first level of appeal must be attached. I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, the $50.00 fee is not required; however, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

**Provider Name:** _____

**Provider Contact Person:** _____

**Phone Number:(_____)_____**

**Provider E-mail (if you want contact by e-mail):** _____

**Provider Signature:**_____

## PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

**New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209**

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.

- For an **experimental / investigational** denial, the patient's physician must complete items **1-12 and 16**.
- For a **clinical trial** denial, the patient's physician must complete items **1-10, 13 and 16**.
- For an **out-of-network** denial, the patient's physician must complete items **1-9, 12 and 16**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 14 and 16**.
- For an **expedited appeal**, the patient's physician must complete items **1-9, 15 and 16**.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Insurance Department or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882.

1. **Name of Physician completing this form:**

_____

To appeal an experimental / investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient's treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.

2**. Physician Address:**

_____

3. **Contact Person:** _____

4. **Phone Number: (_____)_____**

**Fax Number: (_____)_____**

5. **Physician E-mail (if you want contact by e-mail):** _____

6. **Name of Patient:** _____

7. **Patient Address:** _____

8. **Patient Phone Number:**

_____

9. **Patient Health Plan Name and ID Number:**

_____

10. **Complete this item for an external appeal of an experimental / investigational denial or a clinical trial denial. DO NOT complete this item for an appeal of an out-of-network denial or a rare disease denial**. As the patient's physician, I attest: (Select a or b without altering.)

a. ___ The patient has a life-threatening condition or disease with a high probability of causing the patient's death.

**OR**

b. ___ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has or can be expected to last for a continuous period of not less than 12 months; or who, in the case of a child under the age of 18, suffers from any medically determinable physical or mental impairment of comparable severity.

11. **Complete this item for an external appeal of an experimental / investigational denial. DO NOT complete this item for an appeal of a patient's clinical trial participation, an out-of-network denial, or a rare disease denial.** As the patient's physician, I attest: (Select a or b without altering.)

a. ___ Standard health services or procedures have been ineffective or would be medically inappropriate.

OR

b. ___ There does not exist a more beneficial standard health service or procedure covered by the health plan.

12. **Complete this item for an external appeal of an experimental / investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient's clinical trial participation or rare disease.**

**For an experimental / investigational denial:** As the patient's physician I attest that I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. (Complete a and b below.)

**For an out-of-network denial:** As the patient's physician I attest that the out-of-network health service (identify service)

_____

_____

_____

is materially different from the alternate in-network health service recommended by the health plan, and based on the following two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. **(Complete a and b below.)**

a. List the documents relied upon in the space below and **attach a copy of the documents.**

**Document #1 Title**:_____

Publication Name: _____

Issue Number : _____ Date: _____

**Document #2 Title:** _____

Publication Name: _____

Issue Number :_____ Date: _____

b. The medical and scientific evidence listed above meets one of the following criteria *(note peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer):* (**Check the applicable items below for each of the documents**.)

[ ] Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed abstracts accepted for presentation at major medical association meetings;

Document #1 [ ] Document #2 [ ]

[ ] Medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Federal Social Security Act;

Document #1 [ ] Document #2 [ ]

[ ] The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia-Drug Information;

Document #1 [ ] Document #2 [ ]

[ ] Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Document #1 [ ] Document #2 [ ]

13. **Complete this item only for a denial of a patient's participation in a clinical trial.**

a. ___ There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. (**Although not required, it is recommended you enclose the clinical trial protocols and related information.**)

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an

NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

14. **Complete this item only for a rare disease denial.**

As a physician other than the patient's treating physician, I attest the patient has a rare life-threatening or disabling condition or disease. There is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service, the requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service. I **do**____ **do not**____ (**check one**) have a material financial or professional relationship with the provider of the service **AND**: (Select a or b without altering.)

a. ___ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

**OR**

b.___ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

15. **Complete this item only for an expedited appeal.**

If the patient has **not yet received the treatment**, and a **delay would pose an imminent or serious threat to the patient's health**, the patient's physician may request the appeal to be expedited. The external appeal agent must make an expedited decision in 3 days, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. **You must send any information to the agent immediately in order for it to be considered. (Please check one.)**

___**YES**, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 3 days of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at: _____

___**NO,** this appeal does not need to be expedited.

16. **Complete this item for an external appeal of a health plan's denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.**

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

**Physician Name** (Please Print Clearly):

_____

**Signature of Physician** **(Date)**

## EXTERNAL APPEAL INSTRUCTIONS & APPLICATION

Consumers have the right to an external appeal when health care services are denied by an HMO or insurer (health plan) as not medically necessary, experimental/ investigational, a clinical trial, a rare disease treatment, or out-of-network. Providers have their own right to an external appeal when these health care

services are denied concurrently or retrospectively. To request an external appeal, complete the attached application and send it to the New York State Insurance Department within 45 days of the date of the health plan's final adverse determination.

**What Is An External Appeal?** It is a request you make to the New York State Insurance Department when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan's denial.

**When Do I Request An External Appeal?** You must send an external appeal application to the Insurance Department within 45 days from the date of the final adverse determination from the first level of appeal with the health plan OR the health plan's letter waiving the internal appeal process. If your application is not sent to the Insurance Department within 45 days (with an additional 8 days allowed for mailing), you will not be eligible for an external appeal.

**What If A Health Plan Offers A Second Level Of Internal Appeal?** You do not have to request a second level of internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 45 days of the health plan's first level appeal determination.

**What If Services Are Denied As Experimental / Investigational, A Clinical Trial, Or A Rare Disease?** The patient must have a life-threatening or disabling condition or disease and the patient's physician (who for rare diseases may not be the treating physician) must complete and send pages 3-5 of the application to the Insurance Department.

**What If Services Are Denied As Out-Of-Network?** The patient must be covered under an HMO or managed care insurance contract and a pre-authorization request must be denied because the requested service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The patient's physician must complete and send pages 3-5 of the application to the Insurance Department.

**When Will An External Appeal Agent Make A Decision?** In 3 days for expedited appeals or 30 days for standard appeals. The external appeal agent's decision is binding on the patient and the patient's health plan.

**How Do I Request An Expedited (fast-tracked) External Appeal?** The patient's physician must complete pages 3-5 of the application and attest that the patient has not received the treatment and a delay would pose a serious threat to the patient's health. Once an appeal is expedited, a decision will be made in 3 days, even if all of the patient's medical information has not been submitted.

**When Can I Send Information To The External Appeal Agent?** The patient, the patient's designee, and where appropriate the patient's provider, will be notified when an external appeal agent is assigned to the appeal.You must send any information to the agent immediately. Once the agent makes a decision, additional information will not be considered.

**Do I Pay A Fee For An External Appeal?** Some health plans charge $50.00, which is waived for patients who appeal and are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to the patient. The fee will be returned to you if the external appeal agent overturns the health plan's denial.

**What If A Patient Has Medicare Or Medicaid Coverage?** Patients covered under Medicare are not eligible for an external appeal and should call 1-800-MEDICARE or visit www.medicare.gov. Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 1-800-342-3334 or visit www.otda.state.ny.us/oah for fair hearing information.

**What Are My External Appeal Rights If I Am A Health Care Provider?** You have your own right to an external appeal of a concurrent or retrospective final adverse determination. Regardless of whether you appeal on your own behalf, or as the patient's designee, you may not pursue reimbursement from the patient for the health care service if a concurrent denial is upheld by the external appeal agent, except to collect a

copayment, coinsurance, or deductible.

FOR QUESTIONS OR HELP WITH AN APPLICATION CALL THE NEW YORK STATE INSURANCE DEPARTMENT AT 1-800-400-8882 OR VISIT http://www.dfs.ny.gov/insurance/extapp/extappl.pdf