

Neighborhood Health Providers Fraud and Abuse Policy

Healthcare fraud and abuse affects everyone. Many types of fraudulent and abusive acts add up to billions of dollars spent in lost healthcare dollars and higher taxes to support state and federal healthcare programs. The Federal Government addressed the severity of this in Section 6032 of the Deficit Reduction Act of 2005. This act requires all entities that receive significant funding from the Federal Government to educate employees, contractors and agents about the False Claims Act. Neighborhood Health Providers has added information about this new law to its Employee Manual as well as this Fraud and Abuse Policy. All employees have been trained.

NHP knows that the vast majority of its members and providers are honest, however, there are a few individuals who, through fraudulent or abusive acts, illegally collect money and services amounting to billions of dollars.

Neighborhood Health Providers, LLC (“NHP”) is committed to identifying, investigating and preventing fraud and abuse. NHP abides by all applicable statutory and regulatory requirements and state and federal Medicare Advantage, Medicare Part D, Medicaid, Family Health Plus and Child Health Plus program requirements, including State and Federal fraud and abuse laws and regulations. NHP requires all of its members, providers and other subcontractors to comply with applicable statutes, regulations and program requirements. NHP is dedicated to supporting and protecting the integrity of state and federal government sponsored programs and asks for your cooperation.

What is Healthcare Fraud or Abuse?

Fraud is an intentional deception or misrepresentation made by a person who knows the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. The act does not have to be successful, it is enough that the person attempted the deception.

Abuse means incidents or practices that are not usually fraudulent but are inconsistent with sound business, fiscal or medical practices and result in unnecessary costs to the state or federal government or NHP, or in reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care.

COMMON TYPES OF FRAUD

Fraud and abuse can take many forms and can be committed by dishonest physicians, medical equipment suppliers, dentists, laboratories, hospitals and other vendors and health care workers or by NHP members. Some of the common types of fraud committed by providers and members are given below.

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Providers

Provider fraud can take many forms. NHP needs the assistance of its members and providers to identify this type of activity. Examples of provider fraud include:

- Billing for services, procedures and/or supplies that were not provided, e.g. an x-ray that was not taken;
- Double billing, e.g. when a provider bills NHP and also bills Medicaid fee-for service
- Requiring an NHP member to return for unneeded services;
- Performing unnecessary procedures (over-utilization), tests or even surgeries e.g. taking x-rays, performing blood work;
- Upcoding, e.g. providing a simple office visit and billing for a comprehensive visit or performing a simple procedure and billing for a complex procedure;
- Unbundling, e.g. billing for portions of a procedure separately rather than for the whole procedure;
- Having an unlicensed person perform services that only the licensed professional should be performing and then billing as if the licensed professional did perform the service;
- Billing for more service time than actually provided, e.g. counseling or anesthesia;
- Billing for an office visit when there was none, or adding additional family members' names to bills;
- Accepting payment from another provider as payment for referring a patient to that other provider (kickbacks);
- Altering medical records;
- Routinely waiving member co-pays;
- Billing for "phantom" patients who do not exist and did not receive services;
- Billing for more hours than there are in a day.

Members

Member or recipient fraud can take many forms. NHP needs the assistance of its members and providers to identify this type of activity. Examples of member fraud include:

- Loaning an insurance identification card, such as your NHP Medicaid or Medicare Advantage card, to another person or using the card of another person;
- Forging or altering a prescription;
- Using more than one insurance identification card;
- Intentionally receiving duplicative, excessive or conflicting health care services or supplies;
- Re-selling items such as prescriptions or medical supplies received through NHP's Medicaid, FHP, CHP or Medicare Advantage programs;
- Providing false information when applying to NHP in order to try to obtain coverage;
- Using the transportation benefit for non-medical related business

What is the False Claims Act?

The False Claims Act is part of Federal law which sets out the damages or penalties for anyone who knowingly submits false claims to the government. Medicaid and Medicare are government funded health plans and so this provision applies. The penalties for false claims are up to three times the amount of the erroneous payment and between \$5,500 and \$11,000 for each false claim. In addition, this act includes a provision (Qui Tam) which allows an individual (the

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person who discovered and reported the false claim) to bring a law suit on behalf of the US government and receive a portion of the fines and recovery. If the Government decides to take over the case, the individual who filed will receive no less that 15% but not more that 25% of the Federal share of the awarded dollars. If the Government decides not to take over the case, the individual who filed will receive no less that 25% but not more that 30% of the Federal share of the awarded dollars.

In addition, there is a provision in Federal law called the Program Fraud Civil Remedies Act. This provides that anyone who knowingly submits false claims is liable for up to double damages and fines up to \$5000 for each claim.

In New York State, new health care fraud criminal penalties have instituted stiffer penalties based upon the frequency and amount of fraud. Those who provide false information or omit information may be faced with a violation ranging from a Class A misdemeanor to a Class B Felony. There are also civil penalties for insurance fraud of up to \$5,000 and the amount of the claim for each violation.

At NHP we encourage our staff, contractors and agents to report any fraud or abuse without fear of any reprisal. NHP knows how important it is to detect and prevent fraud, waste and abuse.

YOU CAN HELP!

Members can assist NHP with identifying provider fraud by keeping track of the following type of information:

- When you used a healthcare professional service
- Where the service took place
- Who the healthcare professional was who took care of you
- What services were provided during the visit and what additional services did the provider order

If you receive a copy of your explanation of benefits, review it to make sure the services, the name of the provider and the dates of services are correct. If you suspect a provider is billing for more or different services than you actually received, that would be fraud so please notify NHP as soon as possible.

You can also remember the following:

DO NOT give your NHP Medicaid or Medicare Advantage card or card number to anyone other than your doctor, clinic, hospital or other healthcare provider;

DO NOT ask your doctor or any other healthcare provider for medical services or supplies that you do not need;

DO NOT sign your name to a blank form;

DO NOT share your medical records with anyone other than your doctor, clinic, hospital or other healthcare provider

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Providers can assist NHP with identifying member fraud by notifying NHP if you suspect an NHP member of being involved in a fraudulent activity. To help prevent fraud, providers can:

- Ask the member for identification if you are unsure if the individual presenting an NHP identification card is the individual named on the card;
- Notify NHP if you believe an individual has tried to use more than one identification card or a card belonging to another individual;
- Notify NHP if you are concerned because the individual appears to be trying to obtain unnecessary services or supplies.

HOW TO REPORT SUSPECTED FRAUD OR ABUSE:

If you suspect fraud or abuse by a member, provider, vendor, employee or other person or entity working with or for NHP, please notify NHP immediately. You may report your concerns to NHP by calling the number on your identification card, your provider services representative, or by calling NHP's Compliance Hotline.

NHP has established a toll-free Compliance Hotline administered through its affiliate and management services organization, Royal Health Care of Long Island, LLC d/b/a Royal Health Care LLC ("Royal"). Staff, providers, subcontractors, NHP members or other parties can call the Compliance Hotline to report potential violations of NHP's compliance policies or of Federal or State health care program requirements. The toll-free number is listed below.

Compliance Hotline
1-877-655-9900 (toll-free)

Purpose: Easy and ANONYMOUS (if you wish) access to report concerns or suspicions regarding compliance with federal and state law, health care program compliance or ethical standards.

Available: 24 hours a day, 7 days a week. Answered by Compliance office staff (only) from 9 am to 5 pm with confidential voice mail available 24 hours a day. Any calls will be looked into and all callers leaving a name and telephone number will have their calls returned within 24 business hours.

Tell us About: Concerns regarding improper or unethical activity such as inaccurate billing or employee conduct.

Note: The hearing impaired may provide information through the New York Relay Service at: 1-800-877-8973.

Remember, NHP needs your help to fight and prevent fraud and abuse!