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FDR Compliance Newsletter

January 2015

Issue 4

Regulatory updates

Updates to Chapter 4

In November, the Centers for Medicare & Medicaid Services (CMS) updated Chapter 4 of the Medicare Managed Care Manual, titled "Benefits and Beneficiary Protections." CMS will also publish this updated manual online, at a later date. We've highlighted a few changes below:

- **Section 10.5.3**. CMS revised language to clarify Aetna's responsibilities for downstream entities. Plan sponsors, like Aetna, are responsible for how other parties represent Aetna. If a downstream entity offers items or services not part of Aetna's plan benefit package, it cannot reference the plan benefit package in connection with such items or services or describe those items and services as benefits covered by the plan.
- **Section 170**. CMS also described responsibilities when enrollee's receive items and services through referrals by a plan-contracted doctor. If a plan-contracted doctor refers an enrollee to a non-contracted doctor, CMS expects that the plan-contracted doctor will coordinate with Aetna before making that referral. This is to make sure enrollees get medically necessary services covered by their Aetna Medicare Advantage (MA) Plan. Also, contracted doctors should request a pre-service organization determination whenever referring an enrollee for a service that is only covered under certain conditions.

In this issue

Quick links

- Medicare Managed Care Manual
- Medicare Prescription Drug Benefit Manual
- OIG Exclusion List
- GSA Exclusion List
- Aetna's Code of Conduct
- CMS' General Compliance and Fraud Waste and Abuse Training

Aetna maintains a comprehensive Medicare Compliance Program which includes communication with Aetna Medicare FDRs. Dedicated to Aetna's Medicare Compliance Program is John Wells, Medicare Compliance Officer, who is based in Maryland. Questions or concerns for John and/or his Medicare compliance subject matter experts can be sent to the following mailbox: MedicareFDR@aetna.com .

This newsletter is provided solely for your information and is not intended as legal advice. If you have any questions concerning the application or interpretation of any law mentioned in this newsletter, please contact your attorney. ET-0011-15

A Focus on Fraud

What do you think of when you hear "health care fraud?"

The words "health care fraud" often makes you think of greedy providers and billers who take advantage of the insurance industry to make money. But, even worse are organized criminals and schemes that steal millions of dollars from insurance plans. A criminal group may work with medical providers and/or health plan members to pull off these schemes.

When did this all start?

Believe it or not, health care fraud has been a major concern over the past 10+ years. The Medicare and Medicaid programs have been especially prone to fraud. Criminals involved in traditional crimes found that they could make more money in health care fraud at a much lower risk.

Years ago criminal groups:

- Created fake clinics
- Stole IDs from plan members
- Billed false claims to their insurance plans

Then, they'd start the same scheme using different phony provider information. Fraudulent schemes evolved into complex, multi-million dollar enterprises, which are harder to detect. Schemes may involve:

- Patient recruiters
- Medical doctors
- Plan members

What role does the government play?

The federal government took a major step in 2009 to fight organized crime in health care fraud. It developed the Health Care Fraud Prevention and Enforcement Action Team (HEAT) — a collaboration between the Department of Justice (DOJ) and Health and Human Services-Office of Inspector General (HHS-OIG).

This union and stricter policies by CMS helped the fight against health care fraud within Medicare and Medicaid. The DOJ announced earlier this year that they recovered $4.3 billion in 2013. Even with this most recent success, organized criminal activity continues to flourish. Criminals find new ways to get around policies brought on by the government and health insurance companies.

What does fraud look like?

The most common types of health care fraud are:

- Billing for more expensive services or procedures than were provided
- Using stolen member information to bill for services never provided
- Performing medically unnecessary services or falsifying diagnosis to justify unnecessary services
- Accepting kick-backs for patient referrals

If you see or hear anything suspicious that could be considered fraud, report it to us right away. Aetna's Special Investigations Unit has a toll-free fraud hot line to report potential fraud. You can even remain anonymous: **1-800-338-6361.**

Report to Aetna actual or potential fraud, waste and abuse OR non-compliance:

FDRs can have their own internal processes for reporting. But, you must use one of the methods below to report back instances that impact Aetna's Medicare business.

By phone:
1-888-891-8910
(7 days a week, 24 hours a day)

Online:
https://aetna.alertline.com

By mail:
Corporate Compliance
P.O. Box 370205
West Hartford, CT 06137-0205

Toolbox of Resources for FDRs: Training

The Requirement

We require General Compliance and Fraud Waste and Abuse (FWA) training for all employees of FDRs that work on Aetna's Medicare business:

- Within 90 days of hire and
- Annually thereafter.

Also, FDRs must maintain training records for 10 years on:

- The topic of training
- Attendance
- Certificates of completion
- Scores of any tests (if applicable) administered to employees

Don't Have Training in Place?

No need to develop your own. You can download CMS's General Compliance and FWA training or, you can take the training on the Medicare Learning Network (after registration).

Already have Training?

Use this tool to assess how effective your training is. We modeled the tool off CMS' guidance and training modules.

Proof of Training Completion

Use this sample log to document employee completion of CMS's training. You can also modify it to record completion of your own training or share it with downstream entities for their use.

Links not working? Let us know. We're happy to send you a copy of the resources by e-mail.

What is an FDR

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

- Performs some of the Medicare Advantage Organization or Part D plan Sponsor's management functions under contract or delegation; or
- Furnishes services to Medicare enrollees under an oral or written agreement; or
- Leases real property or sells materials to the Medicare Advantage Organization or Part D plan Sponsor at a cost of more than $2,500 during a contract period.