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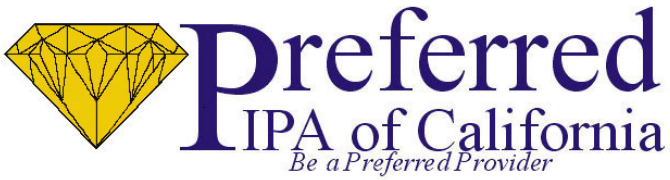

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Fraud, Waste, and Abuse Training

General Compliance Training

HIPAA Compliance Training

2015-2016

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OVERVIEW

This training program consists of three parts:

1. Medicare Parts C & D Fraud, Waste, and Abuse (FWA) Training (Developed by the Centers for Medicare & Medicaid Services Issued: February, 2013)
2. Medicare Parts C & D General Compliance Training (Developed by the Centers for Medicare & Medicaid Services Issued: February, 2013)
3. Preferred IPA HIPAA Compliance Training

At the completion of your initial or annual training, sign the attestation at the end of the training packet.

Providers may **fax** signed attestations to **818-265-0801** Attention: FWA Compliance Attestation.

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Fraud, Waste, and Abuse Training

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Why Do I Need Training?

Every year millions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.

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Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

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Requirements

Statute, regulations, and policy govern the Medicare Parts A, B, C, and D programs.

Part C and Part D contractors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.

In addition, contractors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

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Where do I fit in?

- As a person who provides health or administrative services to a Part C or Part D enrollee you are either:
  - Part C or D Sponsor Employee
  - First Tier Entity
    - Examples: PBM, a Claims Processing Company, contracted Sales Agent
  - Downstream Entity
    - Example: Pharmacy
  - Related Entity
    - Example: Entity that has a common ownership or control of a Part C/D Sponsor

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What are my responsibilities as an employee or a person who provides health and administrative services in the Part C and Part D program?

- You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.
  - FIRST you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
  - SECOND you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
  - THIRD you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

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An Effective Compliance Program

- Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.

- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

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Prevention

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How do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, policies.
- Ensure you coordinate with other payers.
- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.

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Policies and Procedures

- Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

- Make sure you are familiar with your entity's policies and procedures.

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Detection

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What is Fraud, Waste, and Abuse?

In order to detect fraud, waste, and abuse you need to know the Law

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Criminal FRAUD

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

18 United States Code §1347

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What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

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Waste and Abuse

Waste: overutilization of services or other practices that result in unnecessary costs to the Medicare Program. Waste is not cause by criminally negligent actions but by the misuse of resources.

Abuse: includes actions that result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

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Differences between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge.

Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

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Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your sponsor's compliance department . Your sponsor's compliance department area will investigate and make the proper determination.

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Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

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Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

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Key Indicators:

Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)?
- Is the prescription appropriate based on beneficiary's other prescriptions?
- Does the beneficiary's medical history support the services being requested?

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Key Indicators:

Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

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Key Indicators:

Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

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Key Indicators:

Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?

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Key Indicators:

Potential Pharmacy Issues

- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

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Key Indicators:

Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

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Key Indicators:

Potential Manufacturer Issues

- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

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Key Indicators:

Potential Sponsor Issues

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

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How do I report Fraud, Waste, or Abuse?

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Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and abuse. Your sponsor's Code of Conduct and Ethics should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

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Reporting Fraud, Waste, and Abuse

Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your sponsor's materials for the ways to report fraud, waste, and abuse.

When in doubt, call the MA-PD or PDP fraud, waste, and abuse Hotline or the Compliance Department.

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How do I Report?

Suspected Fraud, Waste, & Abuse or other noncompliance may be reported by contacting:

- Medi-Cal (800) 822-6222 or stopmedicalfraud@dhcs.ca.gov
- Medicare (800) 447-8477 or (800) HHS-TIPS
- Anthem (877) 725-2702
- Care 1st (877) 837-6057
- Citizen's Choice (562) 207-4575
- Easy Choice (866) 678-8355
- LA Care (800) 400-4889
- Health Net (800) 977-3565
- Humana (800) 614-4126
- Molina (866) 606-3889
- Preferred IPA (800) 536-2867 or (818)844-8060

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Correction

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Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

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How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

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Laws You Need to Know About

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Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

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Civil Fraud

Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

- 31 United States Code § 3729-3733

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Civil False Claims Act
Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

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Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

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Anti-Kickback Statute

Prohibits:

Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

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Anti-Kickback Statute Penalties

Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

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Stark Statute

(Physician Self Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

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Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

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Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

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HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

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Consequences

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Consequences of Committing Fraud, Waste, or Abuse

- The following are potential penalties. The actual consequence depends on the violation.
  - Civil Money Penalties
  - Criminal Conviction/Fines
  - Civil Prosecution
  - Imprisonment
  - Loss of Provider License
  - Exclusion from Federal Health Care programs

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Scenario # 1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a "regular" customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

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Scenario # 1

A. Fill the prescription for 160
B. Fill the prescription for 60
C. Call the prescriber to verify quantity
D. Call the sponsor's compliance department
E. Call law enforcement

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Scenario # 1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor's compliance hotline. The sponsor will provide next steps.

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Scenario # 2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

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Scenario # 2

A. Do what is asked of your immediate supervisor
B. Report the incident to the compliance department (via compliance hotline or other mechanism)
C. Discuss concerns with immediate supervisor
D. Contact law enforcement

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Scenario # 2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

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Scenario # 3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed.

What do you do?

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Scenario # 3

A. Call Doe Diagnostics and request additional information for the claims
B. Consult with your immediate supervisor for next steps
C. Contact the compliance department
D. Reject the claims
E. Pay the claims

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Scenario # 3 Answer

Answers B or C
Consult with your immediate supervisor for next steps
or
Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

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Scenario # 4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

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Scenario # 4

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacies procedures

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Scenario # 4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

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Congratulations! You have Completed the Centers for Medicare & Medicaid Services' Part C and Part D Fraud, Waste, and Abuse Training

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Compliance Training

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Why do I Need Training?

- Compliance is EVERYONE'S responsibility!
- As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare trust fund.

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Training Objectives

- Understand the organizations commitment to ethical business behavior
- Understand how a compliance program operates
- Gain awareness of how compliance violations should be reported

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Background

- CMS requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors (“Sponsors”) to implement an effective compliance program.
- An effective compliance program should:
  - Provide guidance on how to handle compliance questions and concerns
  - Provide guidance on how to identify and report compliance violations
  - Articulate and demonstrate an organization’s commitment to legal and ethical conduct

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Compliance

A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance

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Compliance Program Requirements

At a minimum, a compliance program must include the 7 core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

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Compliance Training

- CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to the entities with which they partner.

- Having “effective lines of communication” means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

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Ethics – Do the Right Thing!

As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner.

- It's about doing the right thing!
- Act Fairly and Honestly
- Comply with the letter and spirit of the law
- Adhere to high ethical standards in all that you do
- Report suspected violations

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How Do I know What is Expected of Me?

- Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates.
- Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations.
- Everyone is required to report violations of Standards of Conduct and suspected noncompliance.
- An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

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What is Noncompliance?

- Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization's ethical and business policies.
- High Risk Areas:
  - Credentialing
  - Ethics
  - HIPAA
  - Claims, Appeals & Grievances
  - Marketing and Enrollment, Marketing & Enrollment
  - Agent and broker
  - Conflict of Interest

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Noncompliance Harms Enrollees

Without programs to prevent, detect, and correct noncompliance there are:

- Delayed Services
- Denied of benefits
- Difficulty using providers of choice
- Hurdles to care

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Noncompliance Costs Money

- Non Compliance affects EVERYBODY!

- Without programs to prevent, detect, and correct noncompliance you risk:
  - Higher premiums
  - Lower profits
  - Higher insurance copayments
  - Lower benefits for individuals and employers
  - Lower star ratings

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I'm Afraid to Report Noncompliance

- There can be NO retaliation against you for reporting suspected noncompliance in good faith.

- Each Sponsor must offer reporting methods that are:
  - Confidential
  - Anonymous
  - Non-retaliatory

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How Can I Report Potential Noncompliance?

- Suspected Fraud, Waste, & Abuse or other noncompliance may be reported by calling:

Medi-Cal	(800) 822-6222 or stopmedicalfraud@dhcs.ca.gov
Medicare	(800) 447-8477 or (800) HHS-TIPS
Anthem	(877) 725-2702
Care 1st	(877) 837-6057
Citizen's Choice	(562) 207-4575
Easy Choice	(866) 678-8355
LA Care	(800) 400-4889
Health Net	(800) 977-3565
Humana	(800) 614-4126
Molina	(866) 606-3889
Preferred IPA	(800) 536-2867 or (818)844-8060

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What Happens Next?

After noncompliance has been detected

- It must be investigated immediately and then promptly correct any noncompliance

- Correcting Noncompliance
  - Avoids the recurrence of the same noncompliance
  - Promotes efficiency and effective internal controls
  - Protects enrollees
  - Ensures ongoing compliance with CMS requirements

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How do I know the noncompliance won't happen again?

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.

- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures

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Consequences of Noncompliance

- Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:
  - Mandatory Training or Retraining
  - Disciplinary Action
  - Termination

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Compliance Is Everyone's Responsibility

- PREVENT
  - Operate within your organization's ethical expectations to PREVENT noncompliance!
- DETECT & REPORT
  - If you DETECT potential noncompliance, report it
- CORRECT
  - CORRECT noncompliance to protect beneficiaries and to save money!

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What Governs Compliance?

- Social Security Act:
- Title 18
- Code of Federal Regulations*:
- 42 CFR Parts 422 (Part C) and 423 (Part D)
- CMS Guidance:
- Manuals
- HPMS Memos
- CMS Contracts:
- Private entities apply and contracts are renewed/non-renewed each year
- Other Sources:
- OIG/DOJ (fraud, waste and abuse (FWA))
- HHS (HIPAA privacy)
- State Laws:
- Licensure
- Financial Solvency
- Sales Agents

* 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

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Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
- Title XVIII of the Social Security Act
- Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
- Civil False Claims Act (31 U.S.C. §§ 3729-3733)
- Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
- Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
- Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
- OIG Compliance Program Guidance for the Healthcare Industry:
- http://oig.hhs.gov/compliance/compliance-guidance/index.asp

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Congratulations! You have Completed the Centers for Medicare & Medicaid Services' Compliance Training

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HIPAA
Overview of Privacy, Security and HITECH
Staff Training

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Who is Affected by HIPAA?

- Medical practices
- Hospitals
- Ambulatory surgery centers
- Healthcare plans
- Fiscal intermediaries
- Business offices
- Vendors
- Clearinghouses
- Business Associates

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PHI

- PROTECTED HEALTH INFORMATION
- Must be protected from disclosure:
  - At the office
  - In the field
  - On the phone
  - Verbal
  - Documents

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Identifiable Information

- 1. Name
- 2. Any address specification such as street, city, county, precinct, and zip code
- 3. All dates except for the year including birthdate, admission date, discharge date, date of death and all ages over 89
- 4. Telephone number
- 5. Fax number
- 6. Electronic mail address

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Identifiable Information (cont…)

- 7. Social Security number
- 8. Medical record number
- 9. Health plan beneficiary number
- 10. Account number maintained by the healthcare provider
- 11. Certificate or license number such as driver's license number
- 12. Vehicle identifier and serial number including license plate number

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Identifiable Information (cont...)

- 13. Medical device identifier and serial number such as pacemaker serial number
- 14. Web site addresses
- 15. Internet protocol (IP) address number
- 16. Biometric identifier including finger and voice prints
- 17. Full face photographic images and any comparable image, and
- 18. Any other unique identifying number, characteristic or code

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Physical Safeguards

- Relate to policies and procedures ensuring the security of the physical practice to authorized access.
  - Facility Access Controls
  - Workstation Use
  - Workstation Security
  - Device & Media Controls
  - Documents transported to and from meetings in the field

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Willful Neglect

- Conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated.

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Criminal Penalties

- "Knowingly obtain and disclose PHI"

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Penalties

- Criminal penalties up to $100,000
- Actual Damages
- Punitive damages
- Attorney fees
- Costs of investigation

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Breach

- PIPA has to report breaches of unsecured PHI to covered entity then the covered entity may have to notify the Secretary of DHHS.

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- The California Medical Information Act (CMIA) limits the access, use or disclosure of an individual's medical information.

- 56.10(a) No provider of health care, health care service plan, or contractor shall disclose medical information regarding a patient…without first obtaining an authorization, except as provided in subdivision (b) or (c) and as allowed or specified under HIPAA

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Liability for Compensatory Damages

- Any individual may bring action against any person or
  - entity who has negligently released information or records
  - concerning him or her for nominal damages up to $1000
  - and/or the amount of actual damages sustained.

- Any violation that results in economic loss or personal
  - injury to a patient may incur liability for compensatory
  - damages of up to $3000, attorney's fees up to $1000,
  - and the costs of litigation.

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EMAIL SUBJECT LINE

- If the contents (and/or subject line) of e-mails you send contain unsecured "Protected Health Information" (PHI), it is in violation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regarding disclosure of personally identifiable health information.

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- IMPORTANT REMINDERS:

  Emails outside your internal email system are not secure. Do not include member information.

  Obtain enough information from callers to confirm that they are who they state they are before giving out information.

  Do not give out PHI of adult members to family, friends, or others without consent of the patient.

  When in doubt ask a manager.

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WHAT TO DO IF EMAIL IS RECEIVED WITHOUT ENCRYPTION

- Immediately notify the sender that you have received an email that is not “secure” or “encrypted” format so that they can address the compliance issue
- This text is available to all staff to copy and paste into response email:
- Thank you for the email, this email containing Protected Health Information (PHI) was sent without a secure or encrypted format. I wanted to let you know so that you would be aware of the issue and notify your IT department if the encrypted email function failed. It is our policy to notify the sender in these instances, we appreciate your cooperation with our HIPAA policies and procedures.

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Congratulations! You have Completed the Preferred IPA HIPAA Compliance Training

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FWA, COMPLIANCE & HIPAA TRAINING INDIVIDUAL ATTESTATION

_____ I have completed the Preferred IPA of California Annual Fraud, Waste and Abuse training.

_____ I have completed the Preferred IPA of California Annual Compliance training.

_____ I have completed the Preferred IPA of California Annual HIPAA training.

- I understand that I am responsible for reporting possible HIPAA, Compliance and/or Fraud, Waste and Abuse violations that may come to my attention.
- I further understand that when transporting documents that contain HIPAA protected health information, I will do so in a sealed container such as an envelope, folder, zipped bag or other method of transport to secure the documents. I will immediately report to my supervisor the loss of any documents containing protected health information.

IPA/Medical Group Name: Preferred IPA of California

Date: _____Print Name:_____

Signature: _____

Office Name:_____Phone:_____

Fax to 818-265-0801 Attention: FWA Attestation